STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, print paric	00	COMPLETED	
		155232	A. BUILDING		08/12/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		ST NORTH H ST		
TWIN CI	TY HEALTH CARE			TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This visit was f	or a Recertification and	F0000	Submission of this Plan of		
	State Licensure	e Survey		correction does not constitu	te an	
	Ctate Licensus	o carrey.		admission to or an agreeme		
	Survey dates:	August 8, 9, 10, 11,		with facts alleged on the su		
	•	August 6, 9, 10, 11,		report Submission of this Pl		
	and 12, 2011			Correction does not constitu		
				admission or an agreement the provider of the truth of fa	-	
	Facility numbe			alleged or corrections set fo	•	
	Provider numb	er: 155232		the statement of deficiencies		
	Aim number: 1	00266140		Plan of Correction is prepare		
				and submitted because of		
	Survey team:			requirements under State a		
	Ginger McNam	nee. RN. TC		Federal law. Please accept	•	
	Delinda Easter			Plan of Correction as our cr	edible	
	Betty Retherfor	•		allegation of compliance.		
	Karen Lewis, F	KIN				
	Census bed type	pe:				
	SNF/NF: 57					
	Total: 57					
	Census payor	type:				
	Medicare: 5	,				
	Other: 52					
	Total: 57					
	iolai. 31					
	Stage 2 Sampl	e: 30				
	These deficien	cies also reflect state				
	findings cited in accordance with 410 IAC 16.2.					
	IAC 10.2.					
	Quality review com	unleted 8/16/11				
	Cathy Emswiller R	-				
	1		1	İ	1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I4K711

Facility ID:

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155232	B. WING		08/12/2011
	ROVIDER OR SUPPLIER		627 EAS	.DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial status conditions or clinical alter treatment significant changemental, or psychosocial status conditions or clinical alter treatment significant in the facility must a resident and, if known are sident and assignment as speading a change in resided State law or regular paragraph (b)(1) of the facility must resident and the sident and the siden	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the d in §483.12(a). Ilso promptly notify the pown, the resident's legal interested family member range in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or actions as specified in	F0157	F157 NOTIFY OF CHANGES 1A. THE PHYSICIAN FOR RESIDENT #19 HAS BEEN UPDATED ON OPEN AREA 1B. ALL RESIDENTS HAVE POTENTIAL TO BE AFFECT ALL RESIDENTS CURRENTLY REVIEWED A	8. THE FED.

000137

li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN	IG		08/12/2	011
NAME OF	PROVIDER OR SUPPLIER	2	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	ROVIDER OR SOLI EIEI			627 EAS	ST NORTH H ST		
	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	R'S PLAN OF CORRECTION	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	,	ADE	DATE
	form of treatment for 2 of 30 residents				ALL TREATMENT ORDERS APPROPRIATE.	ARE	
	reviewed for family/physician				AFFROFRIATE.		
		Stage 2 Sample of 30.			1C. THE FACILITY'S POLIC	Υ	
	(Resident #19	and #18)			FOR PHYSICIAN/		
					NOTIFICATION HAS BEEN		
	Findings includ	le:			REVIEWED AND NO CHAN	GES	
					WERE INDICATED AT THIS		
	1.) The clinica	I record for Resident			TIME. THE		
	1 '	ved 8/11/11 at 3:00			NURSES HAVE BEEN	CLANI	
	p.m.	ved 6/11/11 at 0.00			RE-EDUCATED ON PHYSIC NOTIFICATION. (ATTACHN		
	P.III.				A)	ILIVI	
	Diagnoses included, but were not				1D. THE DON/DESIGNEE V	VILL	
	. •				REVIEW THE PHYSICIAN		
	· ·	ic bladder, urinary			ORDERS ON		
	retention, diabe				SCHEDULED WORK DAYS		
	1	and history of urinary			ENSURE NOTIFICATION IS	;	
	tract infection.				COMPLETED TIMELY		
					(ATTACHMENT B) 2A. THE PHYSICIAN AND		
	A nursing note	entry, dated 6/10/11 at			FAMILY FOR RESIDENT #1	8	
	11:00 p.m., ind	icated the following:		HAVE BEEN UPDATED			
					ON CONDITION CHANGES	i.	
	"Res [resident]	c/o [complained of]			op 411 pro:==::==	T .	
		et [and] left buttocks			2B. ALL RESIDENTS HAVE		
	_	e. Upon examining			POTENTIAL TO BE AFFECT ALL NURSES	IEU.	
	, ,	se noted open areas to			NOTES REVIEWED TO		
		t rewrote previous			ENSURE PROPER		
		-			NOTIFICATION FOR ANY		
	1	oam to be used to cover			CONCERNS.		
	1 '	til resolved. Order					
	I -	eatment administration			2C. THE FACILITY'S POLIC		
		d. Will continue to			FOR PHYSICIAN & FAMILY		
	monitor."				NOTIFICATION HAS BEEN REVIEWED ANI	ON C	
					CHANGES WERE INDICAT		
	The nursing no	otes lacked any contact			AT THIS TIME.	_0	
	with the physic	ian regarding the			THE NURSES HAVE BEEN		
		oping two open areas			RE-EDUCATED ON PHYSIC	CIAN	
		se writing the order.			& FAMILY		

li ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155232	B. WIN	G		08/12/2	011
NAME OF B	DOLUDED OD GUDDU IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	:		627 EAS	ST NORTH H ST		
	ΓΥ HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
					CROSS-REFERENCED TO THE APPROPRIATE	ΤE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
PREFIX TAG	During an internal Administrator at 8/12/11 at 10:00 information was the nurse writing noted above with physician. The facility failed additional informational information was reviewd p.m. Diagnoses for Fabut were not linichronic urinary urinary retention osteoporosis, attacks. During an internal p.m., a concernal concernal was reviewd to steoporosis.	view on with the nd Consultant RN on 0 a.m., additional requested related to g the treatment order thout contacting the ed to provide any mation as of exit on record for Resident ved on 8/11/11 at 2:00 Resident #18 included, nited to, hypertension, tract infection with n, dementia, and transient ischemic view on 8/8/11 at 2:10 ned family member for xpressed concerns		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	VILL ETED G EWS ING	COMPLETION DATE
	,	not contacting them ent was known to have					
	a condition cha						
	a.m., indicated	dated 7/2/11 at 8:30 "Res b/p [blood '3, p [pulse] 73-at med					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	i i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIEF	2	627 EA	ADDRESS, CITY, STATE, ZIP C ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	[wheelchair] slounresponsive-rub-b/p 74/52, taken to room a Sats [oxygen sa.m. B/p 111/5 [respirations] 1 her shakes and oriented, up in The nursing not information related to the unoted above. A nursing note a.m., indicated reports to write CNAs helped resigns] taken. The weak, r 16, [alert and oriented groggy Will monitor." The next nursing at 10:35 a.m., indicated regarding resigns for the nursing note at 10:35 a.m., indicated regard	responded to chest p 60, r [respiration] 16, and feet elevated - aturation] 96%- at 8:30 k1, p 61, resp 6- res drank some of d was alert and w/c to lunch," Interest entry lacked any ated to contact with the sician and/or family anresponsive episode In dated 7/19/11 at 8:30 less to bed. V/S [vital for the second of t				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155232	B. WIN			08/12/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE				TY, IN46933		
T VVIIV CI	TWIN CITT HEALTH CARE				11, 114-0303		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE
	weakness episode with low pulse and						
	b/p noted above. The notes did not						
	indicated if the	resident's daughter					
	was aware of t	he weakness episode					
	and not just the	e new order for a fiber					
	drink which had	d been received on					
	7/18/11.						
	1710/11.						
	During an interview on with the						
	Administrator and DoN on 8/12/11 at 8:25 a.m., additional information was						
	1 '	ted to the lack of					
	1 * *	family notification of the					
	•	oted above occurring					
	on 7/2 and 7/19	9/11.					
	The facility faile	ed to provide any					
	additional infor	mation as of exit on					
	8/12/11.						
	The current 1/0	06, "Physician & Family					
		ocedure" was provided					
		sultant on 8/12/11 at					
	1 *	purpose of the					
		• •					
	l ·	keep the physician,					
		mily appraised of all					
		ges. The procedure					
	•	hysician was to be					
	1	change in condition					
	that may or ma	y not warrant a change					
	in the treatmer	it plan. The					
		oorted to the physician					
		umented in the nurses					
		th the physician's					
	1	procedure indicated					
	•	•					
	ine resident an	d responsible party					

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155232	B. WING		08/12/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
TIA/INI CI	EV HEALTH CARE			ST NORTH H ST	
	ΓΥ HEALTH CARE		GAS CI	ITY, IN46933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			IAG		DATE
		ed of any change in			
	condition that may or may not warrant a change in treatment plan.				
a change in treatment plan.					
	3.1-5(a)(2)				
	3.1-5(a)(2) 3.1-5(a)(3)				
	3.1-3(a)(3)				
F0241	The facility must p	romote care for residents in			
SS=D		n environment that			
		nces each resident's dignity			
	individuality.	recognition of his or her			
	•	d review and interview	F0241	F 241 DIGNITY AND RESP	ECT 08/29/2011
	the facility failed		102.11	OF INDIVIDUALITY	
	•	eated with dignity		1.RESIDENT #73 WAS	
		ent care and was		IMMEDIATELY INTERVIEW	ĒD
	spoken to in a r			AND MENTAL ANGUISH COMPLETED WITH NO	
	maintained digr			NEGATIVE OUTCOME. 2.AI	LL
	_	were interviewed		OTHER RESIDENTS HAVE	
	related to dignit	ty issues in a stage 2		POTENTIAL TO BE AFFECT	
	sample of 30 (Resident #73)		THEY HAVE BEEN OBSERY AND THEY HAVE BEEN	/EU
	,	•		INTERVIEWED IF ABLE TO	o
	Findings includ	e:		ENSURE THERE ARE NO	
				DIGNITY CONCERNS. 3.TH	_
	The clinical rec	ord for Resident #73		RESIDENT HANDBOOK FO	
	was reviewed c	on 8/8/11 at 1:30 p.m.		HAS BEEN REVIEWED AND	
				CHANGES INDICATED AT 1	
	Resident #73's	current diagnoses		TIME. ALL STAFF HAVE BE	
	included, but w	ere not limited to,		RE-EDUCATED RELATED 1 ABUSE/RESIDENT	Ü
	diabetes mellitu	us, morbid obesity and		RIGHTS/DIGNITY.	
	osteoarthritis.			(ATTACHMENT C) 4. THE	
				SSD/DESIGNEE WILL	
Resident #73 had a healt		nad a healthcare		INTERVIEW 5 ALERT AND	
	plan, dated 6/2	4/11 which indicated		ORIENTED(THIS WILL INCULDE RESIDENTS WHO	<u>, </u>

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155232	B. WING		08/12/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				ST NORTH H ST	
I WIN CI	TY HEALTH CARE		GAS C	ITY, IN46933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	ARE RECEIVING THERAP	DATE
		ad a problem listed		SERVICES) & THE	
as, the resident is dependent upon				DON/DESIGNEE WILL	
	2 staff for activities of daily living.			COMPLETE PERI CARE AL	JDITS
		or this problem		FOR RESIDENTS ON) DI
	· •	ide perineal care		SCHEDULED DAYS OF WO DAYS AS FOLLOWS: DAILY	I
	after each inco	ontinent episode.		TIMES 1 WEEK, 3 TIMES	
	An admission Minimum Data Set			WEEKLY FOR 3 WEEKS, 2	
				TIMES WEEKLY FOR 2	
Assessment, dated 6/21/11,				MONTHS AND RANDOM FOR MONTHS TO ENSURE THE	I
	indicated Resident #73 was totally			ARE NO DIGNITY CONCER	
	dependent upon the staff for			(ATTACHMENT D) RESU	• • • • • • • • • • • • • • • • • • •
	toileting, and bed mobility and the			OF THESE REVIEWS WILL	BE
		requently incontinent		DISCUSSED DURING THE	
	of her bowels.			FACILITY QUARTERLY QA MEETINGS. CORRECTIO	
				DATE: AUGUST 29, 2011	
	During an inter	rview on 8/8/11 at		, , ,	
	9:22 A.M. Resi	dent #73 indicated			
	the staff who c	cared for her did not			
	treat her with o	dignity and respect.			
		ndicated the staff			
	were not gentle				
		ugh" when they			
	cleansed her b	outtocks and perineal			
	area following	incontinent diarrhea			
	episodes. The	resident also			
	indicated a phy	ysical therapist			
	would get mad	l at her when she			
	could not com	plete the exercises			
	the therapist re	ecommended. The			
	resident indica	nted the therapist			
	would sometin	nes raise her voice			
	and spoke in a	n unkind manner.			
	The resident in	ndicated she			
	"dreaded" to g	o to therapy.			
				L	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
THI DI ETHI	or condition	155232	A. BUILDING B. WING	00	08/12/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0248 SS=D	Administrator she indicated to unaware of any Resident #73 hocare. The Admishe was unaware incidents. She facility would incomplaints. 3.1-3(t) The facility must program of activities accordance with the assessment, the immental, and psychinesident. Based on record the facility failed received activities her for 1 of 10 minterviewed relaystage 2 samples. Findings include The clinical received activities according included the stage 2 samples. Findings included the clinical received activities according included the stage 2 samples. Findings included the clinical received activities according included the stage 2 samples.	rovide for an ongoing es designed to meet, in the comprehensive necests and the physical, osocial well-being of each of the esidents who were ested to activities in a et of 30 (Resident #73).	F0248	F248 ACTVITIES MEET INTERESTS/NEEDS OF EAG RESIDENT 1.RESIDENT #73 HAS BEEN RE-ASSESSED BY THE ACTIVITY DIRECTOR TO ASSURE AN ACTIVITIES OF INTEREST HAVE BEEN MET. 2.ALL RESIDENTS HAVE TO BE AFFECT ACTIVITY DIRECTOR/DESIGNEE HAS COMPLETED ACTIVITY QUESTIONNAIRE	N LL HE TED.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTI	ON	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
		155232	B. WIN	IG		08/12/2	011	
NAME OF PROVIDER OR	SUPPLIEI				ADDRESS, CITY, STATE, ZIP CODE			
				627 EAST NORTH H ST				
TWIN CITY HEALTH	CARE		GAS CITY, IN46933					
` ′		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
,		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
		us, morbid obesity and			FOR ALL RESIDENTS TO ASSURE INTERESTARE			
osteoart	osteoarthritis.				ACCURATE.			
					(ATTACHMENT E)			
		had a healthcare						
1 -		15/11, which indicated			3.ACTIVITY			
the resid					DIRECTOR/ACTIVITY ASSISTANT HAVE BEEN			
1 -	problem/strength listed as, resident				EDUCATED EDUCATED			
	establishes her own goals by				ON PROPER DOCUMENTA	ATION		
	deciding how to spend her leisure				AS WELL AS ASSURING			
I	time. Resident sits in lounge area				INTERESTS ARE CURRENT. (ATTACHMENT	· E \		
2-3 time	2-3 times weekly and socializes				CORRENT. (ATTACHIVIENT	Γ)		
with her	with her peers and people watches.				4.ACTIVITY DIRECTOR/			
The goa	l for th	nis problem/strength			DESIGNEE WILL INTERVI	EW 3		
was for	the re	sident to maintain her			INDIVIDUALS ON	NDI4		
current	level a	is evidenced by			SCHEDULED DAYS OF WO			
attendin	g 1-2	activities each week			ONE WEEK,	.0		
thru the	next r	eview. Interventions			3 TIMES WEEKLY FOR 3			
listed w	ere, pr	ovide a monthly			WEEKS, 2 TIMES WEEKLY	FOR		
calenda	r of ac	tivity events, remind			2 MONTHS AND 1 TIME WEEKLY 3 MONTH	e TO		
resident	of ac	tivities of choice and			ENSURE INTERESTS ARE			
interest	s such	as special events			CURRENT. THE			
and soc	ial ho	ur, offer to escort			DON/DESIGNEE WILL MEE			
resident	to an	d from activities of			WITH THE CONSULTANTIN PHARMACIST	NG		
choice a	nd int	erest, and offer and			DURING VISITS TO INFOR	М		
assist ir	mate	rials for independent			THEM OF NEW ADMISSION			
activitie	s of in	terest.			AND WILL REVIEW			
					THEIR REPORT TO ASSUF	RE		
Resider	t #73	had a healthcare			ISSUES ADDRESSED IMMEIDATELY.			
plan, da	ted 6/	15/11 which indicated						
the resi	dent h	ad a problem listed			RESULTS OF THESE REVI			
as, resid	lent ex	chibits depressive			WILL BE DISCUSSED DUR	ING		
I '		ch as being			THE FACILITY QUARTERLY QA			
• •		terventions for this			MEETINGS.			
problem	inclu	ded, provided 1:1's						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155232	B. WING			08/12/2	011
	PROVIDER OR SUPPLIER		•	627 EAS	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE	
	as needed and encourage activities of choice and interest.				CORRECTION DATE: AUGI 29, 2011	JST	
	Review of an " Assessment" findicated Reside following interested; bingo, land country me people watchire events, and read magazines. During an interested indicated the provide he which were of resident indicated for time in high the resident in staff had not provide he which were of resident indicated for the time in high the resident in the resident in staff had not provide he which were of resident indicated for the resident in the resident in the resident in staff had not provide he which were of resident indicated for the resident in the resident	Initial Activity form, dated 6/14/11 dent #73 had the ests and hobbies listening to gospel usic, pet visits, ng, parties, special ading newspapers s. rview with Resident at 9:30 a.m., the ated the facility did r with any activities interest to her. The ated she spent most her room in the bed. adicated the activity rovided her any apers and or read.			23, 2011		
	magazines obs resident's roor A. 8/8/11 at 9:3	served in the m,					
	A. 0/0/11 at 3.3	v A.IVI.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	JG	00	COMPL	ETED
		155232	B. WING			08/12/2	011
		<u> </u>	· ·	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ST NORTH H ST		
TWIN CI	TY HEALTH CARE		I -		TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES	<u> </u>		·		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	B. 8/8/11 at 2:3		1	-			BillE
	D. 0/0/11 at 2.3	ю р.ш.					
	C. 8/9/118/3/11	at 0:00 a m					
	C. 0/9/110/3/11	at 9.00 a.m.					
	D 0/0/44 at 4.0	20					
	D. 8/9/11 at 1:20 p.m.						
	During on into						
	During an inte						
	_	or on 8/10/11 at 1:20					
	· •	on was requested					
		activity staff having					
	provided activities of interest for						
	Resident #73 t	o complete in her					
	room.						
	During an inte	rview with the					
	Activity Direct	or on 8/11/11 at 9:00					
	A.M. she indic	ated when the					
	resident was a	idmitted the facility in					
	June she atter	nded group activities					
	out of her rooi	m. She further					
	indicated the r	esident had a decline					
	in her condition	on and had not been					
		group activities for					
	"quite a while'	-					
	•	ated the activity staff					
		1 activities with					
	Resident #73 i						
	1.69106111 #13	ıı August.					
	Review of the	1:1 documented					
		dent #73, provided by					
	_	rector on 8/10/11 at					
	4:15 p.m. indic	cated,					
	8/1/11, 15 minu	ites, passed					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	e survey pleted /2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	nourishments					
	8/2/11, 15 minu with her noon	ites, helped resident meal				
	· ·	ites, passed ice ent and conversed e felt				
	· ·	ites, helped with I watched the news				
	a.m. she indica	or on 8/11/11 at 9:15 ated the only acility had or Resident #73 were				
	10:00 A.M. she activities listed #73 were part	rsing on 8/11/11 at indicated the d above for Resident of the resident's nd should not have				
	3.1-33(a)					
F0253 SS=E	maintenance serv	rovide housekeeping and ices necessary to maintain , and comfortable interior.				

		(X2) MUI	TIPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155232	B. WING			08/12/2	011
NAME OF E	PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CIT	ΓY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		rvation and interview	F02	53	F253 HOUSEKEEPING &		08/29/2011
		d to ensure resident			MAINTENANCE SERVICES		
	•	pperly maintained and			- 1A. ROOM 122 COVE BASE	:	
		elated to non-secured			WAS IMMEDIATELY REPAIR		
	covebase (roo	m122) , walls in poor					
	repair (room 12	26), closet doors			2A. ALL RESIDENT ROOMS		
	non-functional	(rooms 120 and 213),			HAVE THE POTENTIAL TO	BE	
	chipped windov	v sill (room 120) and			AFFECTED. ALL ROOMS WERE ASSESSED WITH NO	<u> </u>	
	Television cable	e wiring not secured to			FURTHER CONCERNS FOR		
	the walls (room	s 109, 110 and 112)			r erriner deriver and r er	3112.	
	for 8 of 20 resid	dent rooms observed			3A. ALL STAFF HAVE BEEN		
	for environmen	tal concerns (room			RE-EDUCATED ON		
		110, 112, 122 <u>,</u> 126,			COMPLETING		
	120, 213, and 1				WORK ORDERS FOR MAINTENANCE CONCERN	e l	
	, , , , ,	- ,			(ATTACHMENT G)	J.	
	Findings includ	e:			(
	l mamige meres				4A.		
	During the envi	ronmental tour on			ADMINISTRATOR/DESIGNE	E	
	8/10/11 at 1:30				TO COMPLETE		
	Maintenance D				ROUNDS ON SCHEDULED DAYS OF WORK DAYS AS		
	Housekeeping				FOLLOWS:		
		erns were identified,			DAILY TIMES 1 WEEK, 3 TII	MES	
	l lollowing conce	ins were identified,			WEEKLY FOR 3 WEEKS, 2		
	A. Room 122,	under the wall			TIMES	NND.	
	'	nditioner unit, the cove			WEEKLY FOR 2 MONTHS / 1 TIME WEEKLY FOR 3	AND	
		ched from the wall.			MONTHS TO		
					ENSURE COVE BASE IS		
		was detached from			SECURED. (ATTACHMENT	H)	
		ction approximately 3					
	_	The wall board was			1B. ROOM 126 THE BLACK		
	exposed benind	d the cove base.			SCUFF MARKS WERE REPAIRED		
					AND WALL BOARD		
		everal areas of black			REPLACED.		
		re noted across the					
	walls. The wall	board had multiple			2B. ALL RESIDENT ROOMS		
	areas of indent	ations noted.	1		HAVE THE POTENTIAL TO	BE	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155232 X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL A. BUILDING B. WING		WING 08/12/2011			ETED	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE		•	627 EAS	DDRESS, CITY, STATE, ZIP CODE T NORTH H ST 'Y, IN46933		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL C IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
C. Room 120 the off the tracks and a section of Form and missing. D. Room 213 the off the tracks. E. Room 102, the bed in the "B" bed touch and had go Formica. F. Rooms 109, 17 T.V. cables were and were stapled of the cables were in the air. During an interview Maintenance Directly the environmental he was unaware concerns. He fur	closet doors were I the window sill had nica that was chipped closet doors were e footboard of the d was rough to the nuged areas in the 10 and 112 the cable run across the room I to the walls. Some re loose and dangling ew with the ector at the time of al tour, he indicated of any of the above			AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3B.ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDE FOR MAINTENANCE CONCERNS. (ATTACHMEN) 4B. ADMINISTRATOR/DESIGNE TO COMPLETE AUDITS ON SCHEDULED D OF WORK DAYS AS FOLLOWS: DAILY TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS T ENSURE WALLS ARE REPAIRED. (ATTACHMENT 1C & D. ROOM 120 & 213 CLOSET DOORS WERE IMMEDIATELY REPAIRED. ROOM 120 WINDOW SILL REPLACED D/T CHIPP FORMICA. 2C & D. ALL RESIDENT ROO HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOL 3C & D. ALL STAFF HAVE B RE-EDUCATED ON	ERS T G) EE AYS S 1 O TH) PED OMS	

155232 D. WING	
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 627 EAST NORTH H ST GAS CITY, IN46933	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE
COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS. (ATTACHMENT G)	
4C& D.ADMINISTRATOR/DESIGNEE TO COMPLETE AUDITS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS TO ENSURE CLOSET DOORS AND NO CHIPS IN FORMICA. (ATTACHMENT H) 1E. ROOM 102 FOOT BOARD WAS REPLACED AND GOUGED FORMICA WAS REPLACED. 2E. ALL RESIDENT ROOMS HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSED WITH NO FURTHER CONCERNS FOUND. 3E. ALL STAFF HAVE BEEN RE-EDUCATED ON COMPLETING WORK ORDERS FOR MAINTENANCE CONCERNS, (ATTACHMENT G) 4E.ADMINISTRATOR/DESIGNE E TO COMPLETE	

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUILDING	00	COMPLETED 08/12/2011
	ROVIDER OR SUPPLIER		627 E	TADDRESS, CITY, STATE, ZIP CODE AST NORTH H ST CITY, IN46933	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
IAG	REGULATORY OR	LSC IDEN HEYING INFORMATION)	TAG	SCHEDULED DAYS OF WORK DAYS AS FOLLO' DAILY TIMES 1 WEEK, 3 TIMES WEEK 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TIME WEEKLY FOR 3 MONTHS TO ENSURE FOOT BOARD FREE FRO ROUGH EDGES AND FORMICA NO GOUGE FORMICA. (ATTACHMEN) 1F. ROOM 109, 110 AND CABLE CORDS WERE IMMEDIATELY RE-SECURED. 2F. ALL RESIDENT ROOF HAVE THE POTENTIAL TO BE AFFECTED. ALL ROOMS WERE ASSESSE WITH NO FURTHER CONCERNS FOUND. 3F. ALL STAFF HAVE BEI RE-EDUCATED ON COMPLETING WORK OF FOR MAINTENANCE CONCERNS TO ASSURE MAINTENANCE DIRECTO AWARE OF CONCERNS. (ATTACHMENT G) 4F. ADMINISTRATOR/DESIG TO COMPLETE AUDITS ROUNDS ON SCHEDULED DAYS OF WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK,	WS: LY FOR DM GED IT H) 112 MS ED EN RDERS ED CR SNEE

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155232	B. WING		08/12/2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST	
TWIN CI	TY HEALTH CARE		GAS C	ITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0280 SS=D	The resident has to incompetent or oth incapacitated under participate in plant changes in care and A comprehensive developed within 7 of the comprehensiby an interdiscipling attending physicial responsibility for the appropriate staff in by the resident's no practicable, the pathe resident's family representative; and representative; and resident of the staff in the resident's family representative; and representative; and resident of the staff in the resident's family representative; and resident of the staff in the staff in the resident's family representative; and resident of the staff in the	he right, unless adjudged herwise found to be er the laws of the State, to hing care and treatment or and treatment. Care plan must be days after the completion sive assessment; prepared hary team, that includes the ending are in disciplines as determined eeds, and, to the extent articipation of the resident, ly or the resident's legal depriodically reviewed and of qualified persons after	IAU	3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND 1 TII WEEKLY FOR 3 MONTHS ENSURE FOOT BOARD FI FROM ROUGH EDGES AND FORMICA NO GOUGE FORMICA. (ATTACHMENT RESULTS OF THESE REV WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETING CORRECTION DATE: AUG 29, 2011	ME TO REE SED H) IEWS
	the facility failed staff updated the he 20 residents rev	alth care plans for 2 of viewed with health	F0280	F280 RIGHT TO PARTICIPE PLANNING CARE-REVISE 1A. THE CARE PLAN RESIDENT #61 & #73 IMMEDIATED	CP
	care plans in a	Stage 2 Sample of 30.		UPDATED.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		155232	B. WIN			08/12/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R		1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
	TITILALIII OAKL			GAS CI	11, 1140933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Resident #'s 6	31 and 73)					
					1B. ALL RESIDENTS		
	Findings includ	le:			HAVE THE POTENTIAL TO	BE	
					AFFECTED.	τv	
	1 The clinical	record for Resident			ALL NURSING AND ACTIVITION CARE PLANS WERE	I Y	
					REVIEWED TO		
		ved on 8/10/11 at 2:10			ENSURE ACCURACY.		
	p.m.				2.1001(27.00010.01.		
					1C. ALL STAFF HAVE BEEN	ı	
	Current diagno	ses for Resident #61			RE- EDUCATED RELATED		
	included, but w	vere not limited to,			PROPER		
	bipolar disorder, chronic back pain,				DOCUMENTATION OF CAR	RE	
	depression, chronic abdominal pain,				PLANS. (ATTACHMENT A)		
	and history of	•					
	obstructions.	Siriali bowei			1D.THE DON/DESIGNEE &		
	ODSTRUCTIONS.				ACTIVITY		
					DIRECTOR/DESIGNEE WILL REVIEW CARE PLAN	6	
	Decident #64 h	and a booth care when			EVERY QUARTER/ANNUAL		
		nad a health care plan			AND	-L1	
		which indicated the			WITH EVERY CHANGE OF		
		risk for constipation.			CONDITION TO ENSURE		
	An intervention	for this problem			ACCURACY.		
	included monit	or bowel sounds daily.			MEDICAL		
		•			RECORDS/DESIGNEE WIL	L	
	Resident #61's	clinical record lacked			AUDIT 3 CHART AUDITS		
		f daily bowel sounds			ON SCHEDULED DAYS OF		
		•			WORK DAYS AS FOLLOWS	i :	
	being complete	su.			DAILY		
]				TIMES 1 WEEK, 3 TIMES		
	_	view with the DoN, on			WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY		
	8/11/11, at 3 p.	m., she provided			FOR 2 MONTHS AND RAN	DOM	
	documentation	that the daily			FOR 3 MONTHS TO ENSUR		
	monitoring of b	owel sounds had been			CARE PLANS ARE UP TO D		
		n 10/25/10. The health					
		esident #61 had been			RESULTS OF THESE REVI	EWS	
	-	3/11, 4/13/11, and			WILL BE DISCUSSED		
	1 '				DURING THE FACILITY		
	1	iled to indicate the			QUARTERLY QA MEETING	S.	
	daily monitorin	g had been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155232	A. BUI	LDING	00	COMPI 08/12/2	
		155252	B. WIN			00/12/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
					111, 114-0300		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	discontinued.			_	CORRECTION DATE: AUGI	JST	
					29, 2011		
	2.) The clinical	record for Resident					
	#73 was review	ed on 8/8/11 at 1:30					
	p.m.						
		current diagnoses					
	· ·	ere not limited to,					
		us, morbid obesity and					
	osteoarthritis.						
	D						
		nad a healthcare					
	l -	5/11, which indicated					
	the resident ha						
	·	gth listed as, resident					
		r own goals by					
		to spend her leisure					
		t sits in lounge area					
		kly and socializes					
	·	and people watches.					
	_	is problem/strength sident to maintain her					
		s evidenced by					
		s evidenced by activities each week					
		eview. Interventions					
		ovide a monthly					
		tivity events, remind					
		ivities of choice and					
		as special events					
		ir, offer to escort					
		d from activities of					
		erest, and offer and					
		rials for independent					
	activities of inf	•					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE C A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 2/2011
	PROVIDER OR SUPPLIER		627 E	CADDRESS, CITY, STATE, ZIP AST NORTH H ST CITY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	plan, dated 6/1 the resident has, resident ex symptoms such withdrawn. In problem include as needed and of choice and During an inter #73 on 8/8/11 aresident indicated to provide he which were of resident indicated for time in Interesident in the resident in staff had not provide he which were of resident indicated for the time in Interesident in the resident in staff had not provide he which were of resident indicated for the resident in th	terventions for this ded, provided 1:1's I encourage activities interest. rview with Resident at 9:30 a.m., the ated the facility did ar with any activities interest to her. The ated she spent most her room in the bed. Indicated the activity provided her any apers and or read. ation on the s and times Resident room in her bed, newspapers or served in the m,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2011	
	PROVIDER OR SUPPLIEF		STREET.	ADDRESS, CITY, STATE, ZIP CODE IST NORTH H ST ITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	C. 8/9/118/3/11 D. 8/9/11 at 1:2				
	During an inte Activity Direct p.m. information related to the provided activ	•			
	A.M. she indice resident was a June she atter out of her roor indicated the rin her condition attending any "quite a while" Director indicated 1: Resident #73 in Activity Direct not updated the health care play reflect the chart condition and alter the resident accordingly. The 11/08, "Care out of the secondition of	or on 8/11/11 at 9:00 ated when the admitted the facility in aded group activities m. She further resident had a decline on and had not been group activities for '. The Activity ated the activity staff I activities with n August. The or indicated she had he resident's activity an since admission to nge in the resident's the possible need to			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUILDING 08/		COMPLETED 08/12/2011
		199232	B. WING		00/12/2011
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST	
TWIN CI	TY HEALTH CARE		l l	TY, IN46933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			IAG		DATE
	the Administrate	2/11 at 12:35 p.m., by			
		erdisciplinary team in			
		th the resident and the			
		y will develop a care			
		plan is designed to			
	· •	ntified problem areas;			
	•	factors associated			
	with identified p	oroblems. Care plans			
	are to reflect tre	eatment and objectives			
	_	plans are revised as			
	_	resident's condition			
	dictates.				
	3.1-35(d)(2)(B)				
F0282 SS=E		ded or arranged by the ovided by qualified persons			
33-E		n each resident's written			
	plan of care.				
	Based on recor	d review, observation,	F0282	F282 SERVICES BY QUALI	00, = 2, = 0 = -
		he facility failed to		PERSONS/PER CARE PLA	<u>N</u>
		sing staff clarified			
		ders in regards to a		1A. RESIDENT #19 OPTIFC)AM
	•	and readmission		ORDER WAS REVIEWED	
		2 of 4 residents		WITH PHYSICIAN AND DETERMINED TO BE	
		and 73) reviewed the hospital and		APPROPRIATE.	
		the nursing staff did		AB ALL BEGINESITO	T. 15
		ation and/or treatment		1B. ALL RESIDENTS HAVE POTENTIAL TO BE AFFECT	
	orders without			ALL RESIDENTS CURREN	
	physician for 2	•		REVIEWED AND ALL	
	p.130101011 101 Z	5. 55 Toolaonto			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155232	B. WIN	G		08/12/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER			627 EAS	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
	Ι,	9 and 58) reviewed for			TREATMENT ORDERS APPROPRIATE.		
	• •	ers and failed to ensure			ONDERS ALT NOT MATE.		
	the nursing stat				1C. THE NURSES WERE		
		e medications and			EDUCATED THAT ORDERS	;	
	•	e as ordered by the			MUST		
	physician for 3	of 20 residents			BE OBTAINED FROM	.	
	(Resident #'s 7				PHYSICIAN. (ATTACHMENT	(A)	
	reviewed for me	edication			1D. THE DON/DESIGNEE V	/ILL	
	administration i	n a Stage 2 Sample of			REVIEW THE PHYSICIAN		
	30.				ORDERS		
					ON SCHEDULED WORK D	AYS	
	Findings includ	e:			TO ENSURE PHYSICIAN		
					NOTIFICATION IS COMPLE	IED	
	1.) The clinical	record for Resident			TIMELY (ATTACHMENT B)		
	l '	/ed 8/11/11 at 3:00			2A. MEDICATION ERROR		
	p.m.				REPORT COMPLETED FOR	₹	
	F				RESIDENT #9 WITH PHYSI	CIAN	
	Diagnoses inclu	uded, but were not			NOTIFICATION.		
	•	c bladder, urinary			2B.ALL RE-ADMITS HAVE T	HE	
	retention, diabe				POTENTIALTO BE	I IL	
	· ·	and history of urinary			AFFECTED. ALL		
	tract infection.	ind mistory of dimary			RE-ADMISSION ORDERS V	VILL	
	li act infection.				BE		
	A nursing note	entry, dated 6/10/11 at			REVIEWED BY DON/DESIG	INEE	
		•			TO ENSURE PROPER TRANSCRIPTION OF ORD	FRS	
	+1.00 p.m., indi 	cated the following:			TATIOON HONO OF OND	_1.0.	
	UDaa farrida (1	ala faccionalaise et es			2C. THE NURSES HAVE BE	EN	
		c/o [complained of]			RE-EDUCATED ON		
		et [and] left buttocks			PROPER TRANSCRIPTION		
	1 - 1	e. Upon examining			ORDERS. (ATTACHMENT A	.)	
		se noted open areas to			2D. ALL RE-ADMISSION		
		rewrote previous			ORDERS WILL BE REVIEW	ED	
		am to be used to cover			BY DON/DESIGNEE TO		
	'	il resolved. Order			ENSURE PROPER		
	_	atment administration			TRANSCRIPTION		
	record] updated	d. Will continue to			OF ORDERS. (ATTACHME	N I	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN			08/12/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹	-	1	ADDRESS, CITY, STATE, ZIP CODE		
T14/11-1-01	T) / LIE AL TILL OADE			1	ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	-		DATE
	monitor."				B)		
	<u></u> , .				3A.RESIDENT #71 ASSESS	SED	
	1	ites lacked any contact			AND NO HARM NOTED.		
	1	ian regarding the					
	1	oping two open areas			3B. ALL RESIDENTS HAVE		
	prior to the nur	se writing the order.			POTENTIAL TO BE AFFECT RESIDENTS WITH PRN	IED.	
					CLONIDINE ORDERS HAVE	=	
		view on with the			BEEN	=	
	Administrator a	and Consultant RN on			REVIEW TO ENSURE PRO	PER	
	8/12/11 at 10:0	0 a.m., additional			ADMINISTRATION OF MED	S.	
	information wa	s requested related to			00 ALL NUBOEO WEDE		
	the nurse writir	ng the treatment order			3C. ALL NURSES WERE EDUCATED ON PROPER		
	noted above w	ithout contacting the			ADMINISTRATION OF PRI	ı	
	physician.				MEDICATIONS. (ATTACHM		
					A)		
	The facility fails	ed to provide any					
	additional infor	mation as of exit on			3D. THE DON/DESIGNEE V REVIEW RESIDENTS	VILL	
	8/12/11.				WITH BLOOD PRESSURE		
					ORDERS TO ENSURE PRO	PER	
	2.) The clinical	record for Resident # 9			ADMINISTRATION OF PRN		
	was reviewed a	at 8/11/11 at 9:30 a.m.			MEDICATIONS ON		
					SCHEDULED		
	Diagnoses for	Resident #9 included,			WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1		
		mited to, chronic leg			WEEK,		
		us stasis, congestive			3 TIMES WEEKLY FOR 3		
	1	coholic liver disease,			WEEKS, 2 TIMES WEEKLY		
	1	al retardation and			2 MONTHS AND RANDOM		
	dementia.				3 MONTHS (ATTACHMENT	1)	
					4A. FOLEY CATHETER ORI	DER	
	Resident #9 wa	as readmitted from the			WAS IMMEDIATELY OBTAIN		
	hospital on 7/14/11 following treatment for cellulitis, alcoholic liver disease, and diabetes mellitus. Readmission orders sent with the				FOR RESIDENT #73 AND		
					GLUCOSE RESULTS WERE	Ξ	
					OBTAINED	ND	
					FROM 24 HOUR SHEETS A PLACED ON CHART RECO		
					I LAOLD ON CHAIN NECO	ND.	
	president includ	ed, but were not limited					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2011	
		155232	B. WING		08/12/2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP CODE AST NORTH H ST CITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	to, the following below: Levaquin (an a milligrams one order indicated started on 6/16 the medication been complete transcribed to t daily without not a times their given were door twice daily at 7 med was given days in error ar once daily with included for 8/3 period). Fluticasone 0.0 allergy relief) 2 This medication the MAR as "Fl spray 2 sprays time the medical was recorded in p.m., not once was given twice Saline nasal spray) 1 spray times daily. The	g three orders as noted	TAG	4B. ALL RESIDENTS WITH CATHETER ORDERS AND GLUCOSE MONITORING ORDERS WERE VIEWED. 4C. NURSES WERE EDUC ON APPROPRIATE CATHE ORDERS AND NEW GLUC MONITORING PROCEDUF (ATTACHMENT A) 4D. ALL CATHETER ORDER WILL BE REVIEWED BY DON/DESIGNEE TO ENSUAPROPRIATE ORDER OBTAINED. THE DON/DESIGNEE WILL REVIEW RESIDENTS WITH BLOOD GLUCOSE ORDEF ENSURE PROPER ADMINISTRATION OF SLIDING SCALE ORDION SCHEDULED WORK DON SCHE	ERE SATED STER OSE RES. H RS TO ERS AYS Y FOR 1 FOR B & I) WAS ESS. ETHE
	nasai spray 1 s	pray each nostril three		ANY FURTHER ORDERS	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155232	B. WIN	IG		08/12/2011	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			627 EA	ST NORTH H ST		
	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	regulatory or LSC identifying information) times daily." The saline nasal spray			TAG		DATE	
					WRITTEN WITHOUT PHYSICIAN AUTHORIZATION	DNI	
		ed as having been			THISIOIANAOTHORIZATIO) N.	
	given 3 times d	aily through 8/11/11.			5C THE NURSES WERE		
					EDUCATED THAT ORDERS		
	The clinical rec				MUST		
		of the Levaquin,			BE OBTAINED FROM	F A \	
		d/or Saline nasal			PHYSICIAN. (ATTACHMENT	(A)	
		een clarified with the					
		e time of readmission			5D. THE DON/DESIGNEE V	VILL	
	and/or any othe	er occasion.			REVIEW THE PHYSICIAN		
					ORDERS ON SCHEDULED		
	During an inter	view with the			WORK DAYS TO ENSURE NOTIFICATION IS COMPLE	TED	
	Administrator a	nd Director of Nursing			TIMELY ON SCHEDULED		
	on 8/11/11 at 1:	50 p.m., additional			WORK DAYS TO DAYS AS		
	information was	s requested related to			FOLLOWS: DAILY TIMES 1		
	the Levaquin ha	aving been given for			WEEK,		
	another 21 day	s and the errors in the			3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY	EOR	
	Levaquin, Flutio	casone nasal spray,			2 MONTHS AND RANDOM		
	and Saline nas	al spray administration			3 MONTHS (ATTACHMENT		
	as noted above	·.					
					6A. GLUCOSE RESULTS W		
	During an inter	view with the Director			OBTAINED FROM 24 HOUR SHEETS AND PLACED ON	ł	
	_	/12/11 at 1:30 p.m.,			CHART RECORD FOR		
	_	ne nasal spray orders			RESIDENT #60.		
		n clarified. She					
		as still trying to find			6B. GLUCOSE MONITORIN		
	out whether the physician intended for				ORDERS WERE REVIEWE	J.	
		be restarted and					
	given for anoth				6C.NURSES WERE EDUCA	TED	
		•			NEW GLUCOSE		
	3.) The clinical	record for resident			MONITORING PROCEDURI	ES.	
	#71 was reviewed on 8/10/11 at 10:15 a.m.				(ATTACHMENT A)		
					6D. THE DON/DESIGNEE W	/11.1	
					REVIEW RESIDENTS		
	Diagnosis for R	esident #71 included,			WITH BLOOD GLUCOSE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE :	ETED	
		155232	B. WIN			08/12/2	011
	PROVIDER OR SUPPLIER	1		627 EAS	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
		TATEMENT OF DEFICIENCIES		ID I	71, 11410000		(7/5)
(X4) ID PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	but were not line bipolar disorder obstructive pulled. A health care pulled for the diagnosis of hyrisk for complication the diagnosis. For this problem not limited to, "as ordered" and pressure as ordered and pressure as ordered 7/6/11, in was to have he as times daily. The resident was 0.1 mg [milligrates]	nited to, hypertension, r, and chronic monary disease. lan problem, dated ed the resident had a rpertension and was at rations associated with Two of the approaches in included, but were Administer medications d "Monitor blood		ino	ORDERS TO ENSURE PRO ADMINISTRATION OF SLID SCALE ORDERS ON SCHEDULED WORK DAYS TO DAYS AS FOLLOWS: DAILY TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY 2 MONTHS AND RANDOM 3 MONTHS (ATTACHMENT RESULTS OF THESE REVIEWILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS CORRECTION DATE: AUGU 29, 2011	FOR FOR I) EWS	BAIL
	[blood pressure	e) was above 150 and o was above 90.					
	medication adn (MAR) on the for times, the resid	v of the June and July ninistration records ollowing dates and lents b/p was elevated e for the as needed ve been given:					
	6/29/11 at 10 p 7/15 at 10 p.m. 7/17/11 at 10 p	- 170/94					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN	_		08/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TIA/INI OI	TV LIE ALTIL OADE			1	ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		nursing notes for these					
	dates and times	,					
		ated to the blood					
	· •	cation having been					
	_	ed by the physician					
		w-up blood pressure					
	reading having	been taken.					
	The following d	ates and times lacked					
	_	sure having been					
		the blood pressure					
		eded to be given:					
	caication nec	add to be given.					
	June 2 and 3, 2	2011 at 6 a.m.					
	June 4 and 9, 2	2011 at 2 p.m.					
	June 10, 13, 14	l, and 15, 2011 at 6					
	a.m.						
	June 15, 2011 a	at 10 p.m.					
	June 17, 19, 20), 21, 2011 at 6 a.m.					
	June 20 and 21	l, 2011 at 2 p.m.					
	June 30, 2011 a	at 10 p.m.					
	July 19, 2011 a	•					
	July 20, 21, 22,	2011 at 6 a.m.					
	During an inter						
		nd Director of Nursing					
	(DoN) on 8/11/	11 at 8:20 a.m.,					
	additional inform	mation was requested					
	related to the la	ack of medication					
	having been giv	ven on the dates noted					
	above or the bl	ood pressure having					
		ordered on the dates					
	noted above.						
	During an inter	view on 8/12/2011 at					

000137

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 08/12/2	LETED	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	1 007.127	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
TAG	11:30 a.m., the had no informato the medicating given and/or the having been tall above. 4.) The clinical #73 was review p.m. Resident #73's included, but we diabetes melliture osteopathic. Resident #73 was facility on 6/14/ Resident #73 he dated 6/24/11 was resident required catheter due to incontinent of be obesity. During observation a.m. Resident #73 he catheter unwas inside a properties of the c	ad a health care plan, which indicated the problem listed as, the es the use of a Foley, multiple wounds, wowel and morbid attion on 8/8/11 at 9:00 \$\frac{473}{473}\$ was in her room, the resident had an are catheter in place. The room in the side of		TAG	DEFICIENCY)		DATE

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES REPERX REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) Review of Resident #73's clinical record on 8/8/11 at 1:30 p.m. indicated there was no physician's order for the anchored catheter to be continued upon admission to the facility lacked any order for the anchored catheter to be maintained. A physician's telephone order, dated 6/25/11 indicated an order to flush the anchored catheter as needed and anchor new catheter if unable to maintain patency of the current catheter in place. During an interview with the Director of Nursing on 8/8/11 at 2:00 p.m. she indicated the resident was admitted to the facility. The Director of Nursing indicated the nurse who was working when the resident was admitted to the facility should have clarified with the physician at the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155232		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED	
TWIN CITY HEALTH CARE IXA9 ID SUMMARY STATEMENT OF DEPICIENCES TAG REGULATORY OR ISC IDENTIFYING INFORMATION) Review of Resident #73's clinical record on 8/8/11 at 1:30 p.m. indicated there was no physician's order for the anchored catheter to be continued upon admission to the facility. The transfer orders signed by the hospital physician prior to admission to the facility lacked any order for the anchored catheter as needed and anchor new catheter if unable to maintain patency of the current catheter in place. During an interview with the Director of Nursing indicated the could not find an order in the clinical record for the catheter in place. She indicated she could not find an order in the clinical record for the catheter to be maintained following her admission to the facility. The Director of Nursing indicated the rurse who was working when the resident was admitted to the facility should have	NAME OF P	ROVIDER OR SUPPLIEF		•				
Review of Resident #73's clinical record on 8/8/11 at 1:30 p.m. indicated there was no physician prior to admission to the facility lacked any order for the anchored catheter to be maintained. A physician's telephone order, dated 6/25/11 indicated an order to flush the anchored catheter if unable to maintain patency of the current catheter in place. During an interview with the Director of Nursing on 8/8/11 at 2:00 p.m. she indicated the facility from the hospital with a catheter in place. She indicated she could not find an order in the clinical record for the catheter to be maintained following her admission to the facility. The Director of Nursing indicated the nurse who was working when the resident was admitted to the facility should have	TWIN CI	ΓΥ HEALTH CARE						
record on 8/8/11 at 1:30 p.m. indicated there was no physician's order for the anchored catheter to be continued upon admission to the facility. The transfer orders signed by the hospital physician prior to admission to the facility lacked any order for the anchored catheter to be maintained. A physician's telephone order, dated 6/25/11 indicated an order to flush the anchored catheter as needed and anchor new catheter if unable to maintain patency of the current catheter in place. During an interview with the Director of Nursing on 8/8/11 at 2:00 p.m. she indicated the resident was admitted to the facility from the hospital with a catheter in place. She indicated she could not find an order in the clinical record for the catheter to be maintained following her admission to the facility. The Director of Nursing indicated the nurse who was working when the resident was admitted to the facility should have	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
time of admission any orders for		record on 8/8/indicated there order for the a be continued to the facility. The signed by the prior to admiss lacked any order catheter to be. A physician's dated 6/25/11 if flush the anch needed and are unable to main current cathet. During an interprise Director of Nure 2:00 p.m. she in resident was a from the hospilace. She indefined an order if for the catheter following here a facility. The Director of the catheter following when admitted to the clarified with the catheter working when admitted to the clarified with the catheter of the catheter working when admitted to the clarified with the catheter of the	e was no physician's nchored catheter to upon admission to e transfer orders hospital physician sion to the facility der for the anchored maintained. telephone order, ndicated an order to ored catheter as nchor new catheter if ntain patency of the er in place. rview with the rsing on 8/8/11 at indicated the admitted to the facility ital with a catheter in icated she could not in the clinical record er to be maintained admission to the irector of Nursing nurse who was the resident was e facility should have the physician at the					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155232	A. BUI		00	08/12/2	
		155252	B. WIN			00/12/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
			_,		11, 114-0000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	the anchored of	,	+	1710			DITTE
	lile all'olloreu (Jameter.					
	The clinical rec						
	#73 had the foll	lowing diabetic related					
	physician's ord	ers:					
	A. Metformin (a						
	•	00 milligrams 1 orally					
		inal date of this order					
	was 7/10/11.						
	B Monitor bloo	d glucose levels					
		nd at bedtime. 6:30					
		n., 4:30 p.m. and 9:00					
		nal date of this order					
	•	uly 21, 2011 an order					
		decrease blood					
	glucose monito	ring to twice daily 6:30					
	a.m. and 4:30 p	o.m.					
		Novolog sliding scale					
	_	e based on blood					
	_	according to the scale					
	below,						
	 100 -150 = 3 ur	nits					
	151 - 200 = 6 u						
	201 - 250 = 10						
	251 - 300 = 15						
		0 call the physician.					
	-	• •					
	A health care p	lan, dated 6/4/11					
	indicated Resid	dent #73 had a					
	problem listed a	as, the resident has a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155232		(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE S	ETED	
		155232	B. WING			08/12/2	U11
NAME OF I	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE				ST NORTH H ST TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU		abetes mellitus and is		IAG			DATE
	•	riencing hypo or					
		. Interventions for this					
	1	ed, monitor blood					
	1 '	red and administer					
	medication as	ordered.					
	Review of the	June and July 2011					
	"Blood Glucos	_					
	Record" forms	s for Resident #73					
	indicated the r	esident received the					
	incorrect dose	of insulin on the					
	following date	s and times,					
	June 22, 4:30	p.m. blood sugar					
		, no insulin was					
	documented a	s having been given,					
	the resident sl	hould have received 3					
	units.						
	June 26, 6:30	a.m., blood sugar					
	result was 101	, no insulin was					
	documented a	s having been given,					
	the resident sl	hould have received 3					
	units.						
	 July 13, 6:30 a	.m., blood sugar					
	1 -	, no insulin was					
	documented a	s having been given,					
	the resident sl	hould have received 3					
	units.						
	July 14. 9:00 p	.m., blood sugar					
		i, no insulin was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 12011	
	PROVIDER OR SUPPLIER	2	627 EA	ADDRESS, CITY, STATE, ZIP ST NORTH H ST ITY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		s having been given, nould have received 3				
	result was 114 documented a	a.m., blood sugar , no insulin was s having been given, hould have received				
	of Nursing on 8 additional infor related to the la coverage havir	view with the Director 3/11/11 at 3:30 p.m. mation was requested ack of sliding scale ag been documented e dates and time noted				
	of Nursing on 8 she indicated s documentation	view with the Director 3/12/11 at 9:00 a.m. he could not find any to indicate the resident ny insulin on the dates d above.				
	l '	record for Resident ved on 8/10/11 at 2:00				
	included, but w	current diagnoses ere not limited to, and chronic pain.				
	A nursing note	entry, dated 6/7/11				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or conduction	155232		LDING	00	08/12/2	
		.00202	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/ 12/2	
NAME OF I	PROVIDER OR SUPPLIER				ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWDENG N. IN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the fo	llowing,					
		n., "Resident requested					
	•	n for leg and foot pain.					
	Resident had n	o PRN [as needed]					
	pain meds orde						
	hydrocodone [a						
	-	s not due until 0800					
		as in obvious pain.					
		sing judgement and					
		for PRN Tylenol [2]					
		ams] q [every] 6 hours					
	for pain, faxed	to pharmacy"					
	A physician's te	elephone order sheet,					
		nd timed for 3:40 a.m.,					
		der for Tylenol 325 mg					
		The order was signed					
	by the nurse.	3					
	A nursing note	entry, dated 6/30/11 at					
	2:00 p.m. indica	ated, Nurse					
	Practitioner not	ified of PRN Tylenol					
	order and orde	r is OK.					
	. •	view with the Director					
	1	/11/11 at 8:30 a.m. she					
		urse who had written					
		ication order was a					
		ally worked at the					
	l '	urther indicated at the					
	l .	rse could write an					
	1	ol because there were					
	standing order	s" for the medication.					
	The Director of	Nursing indicated at					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTIO 00	NO	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		STR 627	EET ADDRESS, CI EAST NORTI S CITY, IN469			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	OVIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the long term c could not write indicated the pl practitioner sho	are facility a nurse any orders. She hysician and or nurse buld have been called eceived for the Tylenol.					
	l '	record for Resident yed on 8/9/11 at 2:10					
	included, but w	current diagnoses ere not limited to, us and dementia.					
	dated 4/21/11 v resident had a resident has a mellitus and is hypoglycemia a Interventions for monitor blood s	ad a health care plan, which indicated the problem listed as, the diagnosis of diabetes at risk for experiencing and hyperglycemia. For this problem included sugars as ordered and lication as ordered.					
	Resident # 60 h	nad physician's orders g,					
	daily at 6:30 a.ı	d sugar results 4 times m., 11:30 a.m., 4:30 o.m. The original date is 3/31/10					
		antus insulin 8 units / at bedtime. This					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED	
	PROVIDER OR SUPPLIER			627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	order originated C. Administer N insulin according results as listed 141 - 180 = 1 und 181 - 220 = 2 und 221 - 260 = 4 und 261 - 300 = 6 und 301 - 340 = 7 und 341 - 380 = 8 und 381 - 420 = 9 und 421 - 460 = 10 und greater than 46 The sliding scan originated on 3.0 Review of the 30 und Glucose Monitor Resident # 60 ind dose of insuling having been gived attention as having been gived attention as having been should have resulted. July 1, 11:30 and was 176, no insuling having been gived attention as having been gived attention as having been should have resulted.	d on 2/8/10. Novolog sliding scale ag to blood sugar below, nit nits nits nits nits units nits units ocall the physician be insulin orders /31/10 fully 2011 "Blood oring Record" for ndicated the incorrect was documented as yen on the following s, m., blood sugar result sulin was documented igiven. The resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155232	B. WIN			08/12/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
TIANAL OF	TVIIENITIIONDE			1	ST NORTH H ST		
	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	should have red	ceived 1 unit.					
		n., blood sugar result					
		sulin was documented					
		given. the resident					
	should have red	ceived 1 unit.					
	1 *	m., blood sugar result					
	· ·	sulin was documented					
		given. The resident					
	should have red	ceived 2 units.					
		n., blood sugar result					
		sulin was documented					
		given. The resident					
	should have red	ceived 4 units.					
		n., blood sugar result					
	was 141, no ins	sulin was documented					
	as having been	given. The resident					
	should have red	ceived 1 unit.					
	1	m., blood sugar result					
	was 243, no ins	sulin was documented					
	as having been	given The resident					
	should have red	ceived 4 units.					
		n., blood sugar result					
	was 226, no ins	sulin was documented					
	as having been	given. The resident					
	should have red	ceived 4 units.					
	July 4, 11:30 a.	m., blood sugar result					
	was 243, no ins	sulin was documented					
	as having been	given. The resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155232	B. WIN	IG		08/12/2	011
NAME OF F	PROVIDER OR SUPPLIER	\		1	ADDRESS, CITY, STATE, ZIP CODE		
TIA/INI OI	TV LIEALTH CADE			1	ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
	should have re	ceived 4 units.					
	was 145, no insas having been should have re July 6, 11:30 a. was 211, no insas having been should have re July 6, 4:30 p.n was 160, no insas having been should have re July 13, 11:30 a was 146, no insas having been should have re During an inter of Nursing on 8	a.m., blood sugar result sulin was documented in given. The resident ceived 2 units. In., blood sugar result sulin was documented in given. The resident ceived 1 unit. In., blood sugar result sulin was documented in given. The resident ceived 1 unit. In., blood sugar result sulin was documented in given. The resident ceived 1 unit. In., blood sugar result sulin was documented in given. The resident ceived 1 unit. In., blood sugar result sulin was documented in given. The resident ceived 1 unit.					
		mation was requested ack of sliding scale					
		ng been documented					
	_	e dates and time noted					
	above.						
	of Nursing on 8 she indicated s documentation	view with the Director 3/12/11 at 9:00 a.m. the could not find any to indicate the resident ny insulin on the dates					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		no co			(X3) DATE S COMPLE		
ANDILAN	OF CORRECTION	155232	A. BUIL			08/12/20	
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	and times noted						2.112
	3.1-35(g)(2)						
F0309		t receive and the facility					
SS=E		ecessary care and services in the highest practicable					
		and psychosocial well-being,					
	in accordance with	the comprehensive					
	assessment and p		F0/	200	E200 DBOVIDE		00/20/2011
		d review and interview, d to ensure insulin	F0.	309	F309 PROVIDE CARE/SERVICES FOR		08/29/2011
	•	intihypertensive			HIGHEST WELL BEING		
	~	re given as ordered for			- 44 DEOIDENT #74 400E00		
		s (Resident #'s 71, 73,			1A.RESIDENT #71 ASSESS AND NO HARM NOTED.	ED	
	and 60) reviewe	ed for medication					
	administration of				1B. ALL RESIDENTS HAVE POTENTIAL TO BE AFFECT		
		failed to ensure			RESIDENTS WITH PRN	LD.	
		ders were properly			CLONIDINE ORDERS HAVE	<u> </u>	
	•	revent medication residents (Resident			BEEN REVIEW TO ENSURE PROF	PER	
		admitted to the facility			ADMINISTRATION OF MED		
	,	al in a Stage 2 Sample			1C. ALL NURSES WERE		
	of 30.				EDUCATED ON PROPER		
					ADMINISTRATION		
	Findings include	e:			OF PRN MEDICATIONS. (ATTACHMENT A)		
	1) The clinical	record for resident			V. I. I. C. IIII EIVI 7 I		
	,	record for resident red on 8/10/11 at 10:15			1D. THE DON/DESIGNEE W	/ILL	
	a.m.	54 511 6/10/11 at 10.10			REVIEW RESIDENTS WITH BLOOD PRESSURE		
	- 1877-				ORDERS TO ENSURE PRO		
	Diagnosis for R	esident #71 included,			ADMINISTRATION OF PRN MEDICATIONS ON		
	but were not lim	nited to, hypertension,			MEDICATIONS ON		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
		155232	B. WIN			08/12/2	011
	PROVIDER OR SUPPLIER		•	627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST FY, IN46933	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bipolar disorde				SCHEDULED WORK DAYS TO DAYS AS		
	obstructive puil	monary disease.			FOLLOWS: DAILY TIMES 1		
	Δ health care n	lan problem, dated			WEEK,		
	-	d the resident had a			3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY	FOR	
		pertension and was at			2 MONTHS AND RANDOM		
		ations associated with			3 MONTHS (ATTACHMENT	I)	
	•	Two of the approaches			24 MEDICATION EDDOD		
	_	included, but were			2A. MEDICATION ERROR REPORT COMPLETED FOR	₹	
	•	Administer medications			RESIDENT #9 WITH PHYSI		
	,	d "Monitor blood			NOTIFICATION.		
	pressure as ord	dered."					
					2B.ALL RE-ADMITS HAVE TO POTENTIALTO BE AFFECT		
	A recapitulation	of physician's orders,			ALL RE-ADMISSION ORDE		
	dated 7/6/11, in	idicated Resident #71			WILL BE REVIEWED BY		
	was to have he	r blood pressure taken			DON/DESIGNEE TO ENSUI		
	3 times daily	The orders indicated			PROPER TRANSCRIPTION OF ORDERS. (ATTACHMEN		
	the resident wa	s to receive Clonidine			OF ORDERO. (ATTAOHIME)	V 1 D)	
	0.1 mg [milligra	m] one tablet as			2C. THE NURSES HAVE BE	EEN	
	needed if the re	esident's systolic b/p			RE-EDUCATED ON		
	[blood pressure	e] was above 150 and			PROPER TRANSCRIPTION ORDERS. (ATTACHMENT A		
	her diastolic b/p	o was above 90.			ONDENO. (ATTACHMENT A	')	
					2D. ALL RE-ADMISSION		
	_	of the June and July			ORDERS WILL BE REVIEW BY	/ED	
		ninistration records			DON/DESIGNEE TO ENSUI	RE	
	, ,	ollowing dates and			PROPER TRANSCRIPTION		
	· ·	lents b/p was elevated			ORDERS ON SCHEDULED		
		e for the as needed			WORK DAYS TO DAYS AS		
	Clonidine to ha	ve been given.			FOLLOWS: DAILY TIMES 1 WEEK, 3 TII	MFS	
	6/20/11 at 10 a	m 167/09			WEEKLY FOR 3 WEEKS,		
	6/29/11 at 10 p 7/15 at 10 p.m.				2 TIMES WEEKLY FOR 2		
	7/15 at 10 p.m. 7/17/11 at 10 p				MONTHS AND RANDOM FO		
		.III1J 4 /3U			3 MONTHS (ATTACHMENT	B)	
	The MAR and r	nursing notes for these			3A. GLUCOSE RESULTS W	/ERE	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155232	- 1	LDING		08/12/2	
		133232	B. WIN			00/12/2	011
NAME OF	PROVIDER OR SUPPLIEI	3			DDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
				<u> </u>	11, 114-0303		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
	dates and time		+		OBTAINED FROM 24		
		ated to the blood			HOUR SHEETS AND PLAC		
	pressure medication having been given as ordered by the physician and/or any follow-up blood pressure				ON CHART RECORD FOR		
					RESIDENT #60.		
					3B. GLUCOSE MONITORIN	G	
	reading having	•			ORDERS WERE REVIEWE		
	. Jaamig Havilig	Journal Control of the Control of th					
	The following o	dates and times lacked			NO CONCERNS NOTED AT	•	
	_	sure having been			THIS TIME.		
		the blood pressure			3C.NURSES WERE EDUCA	TED	
		eded to be given:			NEW GLUCOSE		
					MONITORING PROCEDURI	ES.	
	June 2 and 3,	2011 at 6 a.m.			(ATTACHMENT A)		
	June 4 and 9,				3D. THE DON/DESIGNEE V	VII I	
	1	4, and 15, 2011 at 6			REVIEW		
	a.m.	,			RESIDENTS WITH BLOOD		
	June 15, 2011	at 10 pm.			GLUCOSE ORDERS TO		
	1	0, 21, 2011 at 6 a.m.			ENSURE PROPER ADMINISTRATION OF SLID	ING	
	June 20 and 2	1, 2011 at 2 p.m.			SCALE ORDERS ON		
	June 30, 2011	at 10 p.m.			SCHEDULED WORK DAYS	TO	
	July 19, 2011 a	at 10 p.m.			DAYS AS FOLLOWS: DAILY	(
	July 20, 21, 22	, 2011 at 6 a.m.			TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2		
					TIMES WEEKLY FOR		
	During an inter	view with the			2 MONTHS AND RANDOM		
	Administrator a	and Director of Nursing			3 MONTHS (ATTACHMEN	IT I)	
	(DoN) on 8/11/	11 at 8:20 a.m.,					
	additional infor	mation was requested					
		ack of medication					
	"	ven on the dates noted			4A. GLUCOSE RESULTS W		
		lood pressure having			OBTAINED FROM 24 HOUR SHEETS AND PLACED ON	₹	
		ordered on the dates			CHART RECORD FOR		
	noted above.				RESIDENT #73		
	 						
	_	view on 8/12/2011 at			4B. GLUCOSE MONITORIN		
	11:30 a.m., the	DoN indicated she			ORDERS WERE REVIEWEI	J.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP - 08/12/2	LETED	
	PROVIDER OR SUPPLIER		STREET 627 EA	AST NORTH H ST ITY, IN46933	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	had no informato the medicatic given and/or the having been tarabove. 2.) The clinical was reviewed as Diagnoses for I but were not lincellulitis, venous heart failure, all anxiety, mentare dementia. Resident #9 was hospital on 7/14 treatment for confident included to, the following below: Levaquin (an amilligrams one order indicated started on 6/16 the medication been complete transcribed to the medication of the medication of the medication been complete transcribed to the medication of the medication of the medication been complete transcribed to the medication of the medication of the medication of the medication been complete transcribed to the medication of the	ellulitis, alcoholic liver labetes mellitus. rders sent with the led, but were not limited g three orders as noted ntibiotic) 500 daily for 21 days (the this med had been limited had been limited l	TAG	4C. NURSES WERE ON NEW GLUCOSE MONITORING PROD (ATTACHMENT A) 4D. THE DON/DESIG REVIEW RESIDENTS WITH BLOOD GLUCO ORDERS TO ENSUR ADMINISTRATION O SCALE ORDERS ON SCHEDULED WORK DAYS AS FOLLOWS: TIMES 1 WEEK, 3 TII WEEKLY FOR 3 WEETIMES WEEKLY FOR 2 MON RANDOM FOR 3 MOD (ATTACHMENT I) RESULTS OF THESE WILL BE DISCUSSED DURING THE FACILI QUARTERLY QA ME CORRECTION DATE 29, 2011	EDUCATED CEDURES. GNEE WILL S COSE RE PROPER OF SLIDING I I DAYS TO E DAILY MES OF SLIDING OF SLID	DATE
		ote of any stop date. medication was to be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED	
		133232	B. WIN	_		06/12/2	011
NAME OF I	PROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE				TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	<u> </u>		-	TAG	DEFICIENCY)		DATE
	twice daily at 7 med was giver days in error a once daily with	cumented in error for a.m. and 7 p.m The atwice daily for three and then rewritten for a stop date now 3/11 (a 21 day time					
	Fluticasone 0.0 allergy relief) 2 This medicatio the MAR as "F spray 2 sprays time the medic was recorded i p.m., not once was given twice. Saline nasal spray 1 spray times daily. The transcribed to the nasal spray 1 spray times daily." The spray times daily." The spray a document given 3 times of the clinical recommendation of Fluticasone, and spray having be	of the Levaquin, nd/or Saline nasal een clarified with the e time of readmission					
	During an inter	view with the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN	IG		08/12/2	U11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		nd Director of Nursing					
		:50 p.m., additional					
		s requested related to					
	-	aving been given for					
	_	s and the errors in the					
	•	casone nasal spray,					
		al spray administration					
	as noted above).					
	Dismin as a sector	damentale that Discretion					
	_	view with the Director					
	_	3/12/11 at 1:30 p.m.,					
		ne nasal spray orders					
		n clarified. She					
		as still trying to find					
		e physician intended for					
	-	be restarted and					
	given for anoth	•					
	,	record for Resident					
		ed on 8/9/11 at 2:10					
	p.m.						
	Dooldont # COL	ourrent diagrassa					
		s current diagnoses					
		ere not limited to, us and dementia.					
	uiabetes mellitt	is and dementia.					
	Docidont #60 h	ad a health care plan					
		ad a health care plan, vhich indicated the					
	· '	problem listed as, the					
		diagnosis of diabetes					
		at risk for experiencing					
		and hyperglycemia.					
		or this problem included					
		sugars as ordered and					
	administer med	lication as ordered.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED	
	PROVIDER OR SUPPLIER			627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	00/12/2	· · ·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	 	nad physician's orders					
	A. Monitor bloodaily at 6:30 a.i p.m. and 9:00 pof this order was been been been been been been been bee	d sugar results 4 times m., 11:30 a.m., 4:30 c.m. The original date as 3/31/10 c.antus insulin 8 units at bedtime. This d on 2/8/10. Novolog sliding scale ag to blood sugar d below, init inits inits inits inits inits inits inits inits inits					
	The sliding sca	0 call the physician le insulin orders					
	Glucose Monito Resident # 60 i dose of insulin	luly 2011 "Blood oring Record" for ndicated the incorrect was documented as ven on the following					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMP 08/12/2	LETED	
	PROVIDER OR SUPPLIER TY HEALTH CARE		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST	00/12/2	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	TY, IN46933 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE TO THE APPRO	BE	(X5) COMPLETION
TAG		m., blood sugar result		TAG	DEFICIENCY)		DATE
	was 176, no ins	sulin was documented given. The resident					
	was 171, no ins	n., blood sugar result sulin was documented given. The resident ceived 1 unit.					
	was 143, no ins	n., blood sugar result sulin was documented given. the resident ceived 1 unit.					
	was 209, no ins	m., blood sugar result sulin was documented given. The resident ceived 2 units.					
	was 234, no ins	m., blood sugar result sulin was documented given. The resident ceived 4 units.					
	was 141, no ins	n., blood sugar result sulin was documented given. The resident ceived 1 unit.					
	was 243, no ins	m., blood sugar result sulin was documented given The resident ceived 4 units.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE :		
		155232	A. BUI B. WIN	LDING		08/12/2	
NAME OF F	PROVIDER OR SUPPLIER		D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
				1	ST NORTH H ST		
	TY HEALTH CARE	TATEMENT OF DEFICIENCIES		L	TY, IN46933		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ME	DATE
TAG	July 3, 4:30 p.m was 226, no ins as having been should have red July 4, 11:30 a. was 243, no ins as having been should have red July 5, 11:30 a. was 145, no ins as having been should have red July 6, 11:30 a. was 211, no ins as having been should have red July 6, 4:30 p.m was 160, no ins as having been should have red July 13, 11:30 a was 146, no ins	n., blood sugar result sulin was documented given. The resident ceived 4 units. m., blood sugar result sulin was documented given. The resident ceived 4 units. m., blood sugar result sulin was documented given. The resident ceived 1 unit. m., blood sugar result sulin was documented given. The resident ceived 2 units. n., blood sugar result sulin was documented given. The resident ceived 2 units. n., blood sugar result sulin was documented given. The resident ceived 1 unit. a.m., blood sugar result sulin was documented given. The resident ceived 1 unit.		TAG			DATE
	of Nursing on 8 additional inforr	view with the Director /11/11 at 3:30 p.m. mation was requested ack of sliding scale					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN			08/12/2	UTT
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
TMANAGE					ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	_	ig been documented					
	-	dates and time noted					
	above.						
	During an interview with the Director of Nursing on 8/12/11 at 9:00 a.m. she indicated she could not find any						
		to indicate the resident					
		ny insulin on the dates					
	and times noted	d above.					
	40 = 10 + 10 + 10 + 10 + 10 + 10 + 10 + 1						
	,	record for Resident					
		ved on 8/8/11 at 1:30					
	p.m.						
	D : + # 7 0! -						
		current diagnoses					
		ere not limited to,					
		us, morbid obesity and					
	osteoarthritis.						
	Decide::4 #70 !-	ad physicianic and an					
		ad physician's orders					
	for the following	J ,					
	A Mottormin (-	an oral diabatia					
	A. Metformin (a						
	•	00 milligrams 1 orally					
	,	inal date of this order					
	was 7/10/11.						
	D Monitor bloo	d alugada layala					
		d glucose levels					
		nd at bedtime. 6:30					
		n., 4:30 p.m. and 9:00					
		nal date of this order					
	was 6/14/11. J	uly 21, 2011 an order					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155232	A. BUIL	DING	00	COMPL 08/12/2	
		133232	B. WING			00/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE				TY, IN46933		
					11, 114-0000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
		decrease blood					
		ring to twice daily 6:30					
	a.m. and 4:30 p.m.						
	C Administer N	Novolog sliding scale					
	insulin coverage based on blood						
	_	according to the scale					
	below,						
	,						
	100 -150 = 3 ur	nits					
	151 - 200 = 6 units						
	201 - 250 = 10	units					
	251 - 300 = 15 units greater than 300 call the physician.						
	A health care p	lan, dated 6/4/11					
	indicated Resid	dent #73 had a					
	problem listed a	as, the resident has a					
	diagnosis of dia	abetes mellitus and is					
	at risk for expe	riencing hypo or					
	hyperglycemia.	Interventions for this					
	•	ed, monitor blood					
		red and administer					
	medication as o	ordered.					
		June and July 2011					
	"Blood Glucos	_					
		for Resident #73					
		esident received the					
		of insulin on the					
	following dates	s and times,					
	luma 00 4-00	blacd ov					
		o.m. blood sugar					
	resuit was 102	, no insulin was					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 7/2011
	PROVIDER OR SUPPLIER	2	627 EA	ADDRESS, CITY, STATE, ZIP ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		s having been given, nould have received 3				
	result was 101 documented a	a.m., blood sugar , no insulin was s having been given, nould have received 3				
	result was 100 documented a	.m., blood sugar , no insulin was s having been given, nould have received 3				
	result was 126 documented a	o.m., blood sugar is, no insulin was is having been given, inould have received 3				
	result was 114 documented a	a.m., blood sugar , no insulin was s having been given, hould have received				
	of Nursing on 8 additional infor related to the la	view with the Director 8/11/11 at 3:30 p.m. mation was requested ack of sliding scale ag been given on the noted above.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
THEFTERN	or connection	155232	A. BUI			08/12/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORT OR	LSC IDENTIFT ING INFORMATION)		IAU			DATE
	of Nursing on 8 she indicated s indication the re	view with the Director /12/11 at 9:00 a.m. he could not find any esident had received ates and times noted					
	facility policy, administration Procedure" pro	ovided by the on 8/12/11 at 8:00					
		ccording to the forth by the State					
	Procedure:						
	be recorded or administration [treatment adm after given" The current 1/1 "Hypoglycemia was provided b 8/12/11 at 8:00 indicated nursir	results of the blood					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 627 EAST NORTH H ST GAS CITY, IN46933				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	party, specific t	ications of responsible reatment used, onse to the treatment, up.					
	Administration was provided b 8/12/11 at 8:00 indicated the m	will be recorded on the					
	3.1-37(a)						
F0315 SS=E	assessment, the firesident who enteresident who enteresident's clinical that catheterization resident who is incompropriate treatment urinary tract infect normal bladder fur Based on obset and interview, the ensure each rean anchored catefor the resident.	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless cal condition demonstrates in was necessary; and a continent of bladder receives tent and services to prevent ions and to restore as much inction as possible. rvation, record review, the facility failed to sident had an order for atheter currently in use (Resident #73), failed eter tubing was not	F0315	F315 NO CATHETER,PREV UTI,RESTORE BLADDER -	08/29/2011 ENT		

	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			
155232 B. WING	08/12/2	2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	•		
627 EAST NORTH H ST			
TWIN CITY HEALTH CARE GAS CITY, IN46933			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	O BE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)		DATE	
allowed to lie on the floor (Resident	ODDED		
#19), and falled to ensure each	ONDEN		
resident had catheter orders that CLARIFIED FOR RESID	DENT		
included the size of the catheter and #25			
bulb for 4 of 5 (Resident #73, 18, 19,			
and 25) residents reviewed with			
anchored Foley catheters in a Stage 2 CATHETER ORDERS W REVIEWED.	/EKE		
Sample of 30.			
1C. NURSES WERE ED	UCATED		
Findings include: ON APPROPRIATE CAT	HETER		
ORDERS			
1.) The clinical record for Resident (ATTACHMENT A)			
#25 was reviewed on 8/10/11 at 3:00	DERS		
p.m. WILL BE REVIEWED BY			
DON/DESIGNEE TO EN			
The resident had current diagnoses APPROPRIATE ORDER			
which included, but were not limited OBTAINED OBTAINED ON SCHEDU	II ED		
to, acute renal failure, history of DAYS OF WORK DAYS			
urinary tract infection, hydronephrosis, FOLLOWS:			
and history of bladder tumor. The DAILY 1 TIME WEEKLY	, 3		
resident was receiving hospice	_		
services. FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTH			
AND RANDOM FOR 3 I			
A recapitulation of physician's orders, (ATTACHMENT B)	5		
signed 7/6/11, included, but was not			
limited to "Change catheter monthly			
and pro [as peeded]". The original ZA. FOLEY CATHETER	URDER		
date of this order was 11/30/10. The CLARIFIED AND TUBIN	G		
order lacked any information related IMMEDIATELY REPOSIT	_		
to the size of the catheter and bulb to FOR RESIDENT #19			
he used for the resident			
2B. ALL RESIDENTS W	IIH		
During an interview on 8/11/11 at 8:20 CATHETER ORDERS WERE REVIEWED AND			
a.m., additional information was CATHETER TUBING WA			
requested related to the size of the CHECKED FOR PROPE			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155232	B. WIN			08/12/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
I WIIN CI	IT HEALITI CARE			GAS CI	11, 11140933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		ılb to be used for			PLACEMENT.		
	Resident #25.				20 NUBSES WEDE EDUS	,TED	
	On 8/11/11 at 2:00 p.m., the DoN				2C. NURSES WERE EDUCA ON APPROPRIATE	אובט	
					CATHETER ORDERS AND		
		y of a clarification			TUBING PLACEMENT		
		11/11, for Resident			(ATTACHMENT A)		
		The order indicated					
	the resident was to have a size 18				2D. ALL CATHETER ORDER	RS	
					WILL BE REVIEWED BY		
	` '	eter with a 30 cubic			DON/DESIGNEE TO ENSU		
	centimeter (cc)	DUID.			APPROPRIATE ORDER AN THAT CATHETER TUBING		
	2.) The clinical record for Resident #				NOT DRAGGING ON FLOO		
					OBTAINED ON SCHEDULE		
	19 was reviewe	ed on 8/11/11 at 3:00			DAYS OF WORK DAYS AS		
	p.m.				FOLLOWS: DAILY TIMES 1		
					WEEK, 3 TIMES WEEKLY F		
	Diagnoses inclu	uded, but were not			3 WEEKS, 2 TIMES WEEKL	I	
	_	c bladder and urinary			FOR 2 MONTHS AND RANG	DOM	
	· ·	etes mellitus, and			FOR 3 MONTHS		
	· ·	ry tract infection.			(ATTACHMENT B & J)		
		y trade infection.			3A. FOLEY CATHETER ORI	DER	
	A catheter acce	essment dated 5/0/11			WAS IMMEDIATELY		
		essment, dated 5/9/11,			CLARIFIED FOR RESIDEN	Г#18	
		esident required the					
		elling catheter due to			3B. ALL RESIDENTS WITH		
	_	n and an atonic			CATHETER ORDERS		
		ssessment indicated			WERE REVIEWED.		
		d required a 16 fr			3C. NURSES WERE EDUCA	ATED	
	catheter with a	10 cc bulb.			ON APPROPRIATE	"-5	
					CATHETER ORDERS		
	A recapitulation	of physician's orders,			(ATTACHMENT A)		
	•	idicated Resident #19					
		r catheter changed					
	every month. The orders lacked any information related to the size of the				3D. ALL CATHETER ORDER	RS	
					WILL BE REVIEWED BY	_{>}	
		bulb that was to be			DON/DESIGNEE TO ENSU APPROPRIATE ORDER	\[
					OBTAINED ON SCHEDULE	n	
	used for the res	siaent.			OBIAINED ON SCHEDULE	ا ا ا	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPI	LETED
		155232	1	LDING		08/12/2	2011
			B. WIN		DDDEGG CITY CTATE TIN CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					DAYS OF WORK DAYS		
	During observa	ations on 8/8/11 at			AS FOLLOWS: DAILY TIME	S 1	
	11:40 a.m. and 8/10/11 at 11:00 a.m.,				WEEK, 3 TIMES WEEKLY		
	Resident #19 v				FOR 3 WEEKS, 2 TIMES		
		•			WEEKLY FOR 2 MONTHS	ITLIO	
		d her catheter tubing			AND RANDOM FOR 3 MON	NIHS	
	was lying on the floor underneath her chair. During an interview with the				(ATTACHMENT B)		
					4A. FOLEY CATHETER OR	NER	
					WAS IMMEDIATELY	DLI	
					OBTAINED FOR RESIDEN	T #73	
	Administrator and DoN on 8/11/11 at						
	8:20 a.m., additional information was				4B. ALL RESIDENTS WITH		
	requested related to the size of the				CATHETER ORDERS AND		
		ulb to be used for			4C. NURSES WERE EDUC	ATED	
		and they were notified			ON APPROPRIATE		
	of the observa	tions of the catheter			CATHETER ORDERS		
	tubing on the f	loor.			(ATTACHMENT A)	50	
					4D. ALL CATHETER ORDE	RS	
	On 8/11/11 at 2	2:00 p.m., the DoN			WILL BE REVIEWED		
		y of a clarification			BY DON/DESIGNEE TO ENSURE APPROPRIATE		
	1 .	11/11, for Resident			ORDER OBTAINED ON		
	· ·				SCHEDULED DAYS OF WO	ORK	
		The order indicated			DAYS AS FOLLOWS: DAIL		
		as to have a size 18			TIMES 1 WEEK, 3 TIMES		
	French (fr) cat	neter with a 30 cubic			WEEKLY FOR 3 WEEKS, 2	2	
	centimeter (cc)) bulb.			TIMES WEEKLY FOR		
					2 MONTHS AND RANDOM	FOR	
	3.) The clinica	I record for Resident			3 MONTHS (ATTACHMENT	B)	
	1 '	ved on 8/11/11 at 2:00					
	p.m.					ITMC	
	Y.'''.				RESULTS OF THESE REVI	EVV2	
	Diameter	Desident #40 in alcolad			ISCUSSED DURING THE		
	Diagnoses for Resident #18 included, but were not limited to, hypertension,				FACILITY QUARTERLY		
					QA MEETINGS.		
	chronic urinary	tract infection with			2,22		
	urinary retention	on, dementia,			CORRECTION DATE: AUG	UST	
	,	and transient ischemic			29, 2011		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155222		(X2) MI A. BUII		NSTRUCTION 00	COMPI	LETED	
		155232	B. WIN			08/12/2	011
	PROVIDER OR SUPPLIER			627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	attacks.						
	signed 8/3/11, i limited to "Place and change moneurogenic blace date of this order lacked and to the size of the the resident. During an interval	dder." The original er was 5/18/11. The hy information related he bulb to be used for view on 8/11/11 at 8:20 Information was ed to the size of the hulb to be used for 1:00 p.m., the DoN y of a clarification 11/11, for Resident The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has to have a size 18 heter with a 30 cubic bulb. The order indicated has the order indicated					
	Resident #73 w	as admitted to the					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	e survey pleted /2011
	PROVIDER OR SUPPLIEF		627 EA	ADDRESS, CITY, STATE, ZIP O ST NORTH H ST ITY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAG	facility on 6/14/ Resident #73 h dated 6/24/11 v resident had a resident require catheter due to incontinent of to obesity. During observa a.m. Resident i in her bed. The anchored Foley The catheter u was inside a pr catheter was si the resident's to Review of Res record on 8/8/i indicated there order for the a be continued to the facility. Th signed by the prior to admis lacked any ord catheter to be The 1st note of order related to a catheter was	and a health care plan, which indicated the problem listed as, the es the use of a Foley, multiple wounds, powel and morbid ation on 8/8/11 at 9:00 #73 was in her room, eresident had an y catheter in place, rinary drainage bag rivacy bag. The ecured on the side of bed. ident #73's clinical 11 at 1:30 p.m. If was no physician's inchored catheter to upon admission to eransfer orders hospital physician sion to the facility der for the anchored maintained. If any physician's of the resident having	IAG			DAIE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	COMPLETED	
		155232	B. WIN			08/12/2	011	
		<u> </u>	D. (11)		ADDRESS, CITY, STATE, ZIP CODE	I		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ST NORTH H ST			
TWIN CITY HEALTH CARE				GAS CI	TY, IN46933			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
		ed an order to flush						
		catheter as needed						
	and anchor ne	w catheter if unable						
	to maintain patency of the current							
	catheter in place.							
	A physician's	telephone order,						
	dated 7/11/11 indicated the following, obtain a urinalysis and culture and sensitivity test related to resident complaints of burning							
	and urinary urgency.							
	Δ laboratory μ	rinalysis test report,						
	dated 7/12/11,	• •						
	•	plus blood, nitrates						
		bacteria in her urine.						
		was called the test						
		order was received						
		Bactrim double						
	• •	ntibiotic) 1 orally						
	_	7 days to treat a						
	urinary tract ir	nfection.						
	During an inte							
	Director of Nu	rsing on 8/8/11 at						
	2:00 p.m. she	indicated the						
	resident was a	admitted to the facility						
	from the hosp	ital with a catheter in						
	place. She ind	icated she could not						
	find an order i	n the clinical record						
	for the cathete	er to be maintained						
		to the facility. The						
		rsing indicated the						
	Pirector of Nu	ionig maioatea tile						

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TPLE CON	NSTRUCTION 00	(X3) DATE S COMPL	
THIE TEAT	or condition	155232	A. BUILDI	NG		08/12/2	
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ST NORTH H ST		
TWIN CI	TY HEALTH CARE				ΓY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	AG	DEFICIENC!)		DATE
		s working when the					
		dmitted to the facility					
		arified with the					
physician at the time of admission							
	any orders for	tne anchored					
	catheter. The current 9/05 "Foley Catheter						
	Maintenance P						
		Administrator on					
	'	a.m. The procedure					
		<u>-</u>					
indicated the catheter tubing should not touch the floor.							
		JOI.					
	3.1-41(a)(1)						
	3.1-41(a)(2)						
	(4)						
	6. 334						
F0323		nsure that the resident ins as free of accident					
SS=D		sible; and each resident					
		supervision and assistance					
	devices to prevent	accidents.					
			F032	3	F323FREE OF ACCIDENT		08/29/2011
		rvation, record review,			HAZARDS/SUPERVISION/ DEVICES		
	· ·	he facility failed to			<u> </u>		
		tions used to help			1A. CALL LIGHT WAS		
	prevent falls we	•			IMMEDIATELY PLACED WIT	ΓHIN	
	ndicated in the 6 residents revi	ir plan of care for 2 of			REACH FOR RESIDENT #18		
		Stage 2 Sample of 30.			. CRALOIDEITI II IO		
	(Resident #18 a				1B. ALL RESIDENTS HAVE	THE	
	(1769106111#106	anu #33)			POTENTIAL TO BE		
	Findings include:				AFFECTED. ALL WERE VISUALIZED TO ENSURE APPROPRIATE CALL LIGHT		
		Findings include:					
	 1) The clinical	record for Resident			PLACEMENT.		
	,	red on 8/11/11 at 2:00					
	" TO WAS TOVIEW	54 511 5/ 11/ 11 at 2.00					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPLETED	
		155232	A. BUII		-	08/12/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER						
TIA (IN 1 O)	T) /				ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	p.m.				1C. ALL STAFF WERE		
	•				EDUCATED ON APPROPRI	ATE	
	Diagnoses for Resident #18 included,				CALL LIGHT PLACEMENT.		
	but were not limited to, hypertension,				(ATTACHMENT C)		
	1				1D DON/DESIGNEE WILL		
	chronic urinary tract infection with				1D. DON/DESIGNEE WILL COMPLETE		
	urinary retentio				AUDIT CALL LIGHT		
	•	ind transient ischemic			PLACEMENT ON SCHEDUL	_{-ED}	
	attacks.				DAYS OF WORK AS		
					FOLLOWS: DAILY TIMES 1		
	During an inter	view on 8/8/11 at 2:10			WEEK,		
	p.m., a concerr	ned family member for			3 TIMES WEEKLY FOR 3		
	Resident #18 e	xpressed concerns			WEEKS, 2 TIMES WEEKLY		
		nt's call light frequently			2 MONTHS AND RANDOM		
		reach for her to use			3 MONTHS (ATTACHMENT	J)	
	to request assis				 2A. ALARM WAS IMMEDIAT	-FIV	
	lo request assis	Starice.			PLACED ON RESIDENT #5		
	A 115 11 5: 1 A				BED.		
		sessment", dated					
	=	ed Resident #18 was a			2B. ALL RESIDENTS HAVE	THE	
		a history of falls,			POTENTIAL TO BE AFFECT		
	confusion, unst	eady gait, and			ALL WERE VISUALIZED TO	l l	
	weakness.		ENSURE APPROPRIATE ALARM			ARM	
					PLACEMENT.		
	A health care p	lan problem, updated			2C. ALL STAFF WERE		
	· ·	ated Resident #18 was			EDUCATED ON APPROPRI	ATE	
	at risk for falls.				ALARM		
		prevent falls was "call			PLACEMENT. (ATTACHMEI	NT A)	
	light in reach."	proventialis was call					
	ingrit in reacil.				2D. DON/DESIGNEE WILL		
	During observation on 8/10/11 at 8:15 a.m., Resident #18 was up in her wheelchair in her room facing the door with her back to the bed. The resident's eyes were closed and she				COMPLETE AUDIT		
					ALARM PLACEMENT ON		
					SCHEDULED DAYS OF WC AS FOLLOWS: DAILY TIME		
					WEEK, 3 TIMES WEEKLY F		
					3 WEEKS, 2 TIMES WEEKI		
					FOR 2 MONTHS AND RANI		
	_	dozing. The call light			FOR 3 MONTHS		
		3 3			(ATTACHMENT J)		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/12/2011	
	PROVIDER OR SUPPLIER	!!	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST ITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	was lying on the resident. During an obset 10:00 a.m., Restransferred from was now in here elevated. The the resident's the reach. LPN the resident's rewas placed with time. 2.) The clinical #53 was review a.m. Diagnoses for the but were not lindisease, leuker disorder, and prodisorder. A "Fall Risk Asset 6/14/11, indicated fall risk due to a confusion, unstransferred fell on when he atternished.	e bed behind the ervation on 8/10/11 at sident #18 had been in the wheelchair and is recliner with her feet call light was still on bed, but was not within N #1 was summoned to soom and the call light thin her reach at that I record for Resident wed 8/10/11 at 8:45 The resident included, mited to, Alzheimer's mia, depressive ersistent mental seessment", dated the Resident #53 was a see history of falls, teady gait, and	IAU	RESULTS OF THESE REV WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETING CORRECTION DATE: AUG 29, 2011	TIEWS

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		A. BUILD		NSTRUCTION 00	(X3) DATE: COMPL 08/12/2	ETED	
	PROVIDER OR SUPPLIER			627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on 7/18/11, ind was at risk for fapproaches to "sensor alarm i A physician's o indicated Residue sensor alarm wheelchair. During an obse 8:35 a.m., Residue his bed. The rehad one foot of No alarm box worder for the promoter fo	ervation on 8/10/11 at dent #53 was lying in sident was awake and if the edge of the bed. was noted on the bed in essure pad to signal was removed from the box was present on wheelchair in the room. Immoned to the room: 37 a.m. She was an alarm box on the She removed the					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2011
		100202	B. WING	TADDRESS, CITY, STATE, ZIP CODE	00/12/2011
NAME OF	PROVIDER OR SUPPLIER			AST NORTH H ST	
TWIN CI	TY HEALTH CARE			CITY, IN46933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0329 SS=D	the bed for use pad. The current 9/0 Reduce Fall Ris by the administ 8:00 a.m. The call light should resident's reach an equipment in alarm attached 3.1-45(a)(2) Each resident's driften unnecessary drug is any drug without adequate in the presence of account in a compare sident, the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discounted to discontinued; or are sidents who use gradual dose reduinterventions, unlein an effort to discounted to	with that pressure 5, "Interventions to sk" policy was provided rator on 8/12/11 at policy indicated the be placed in the n. The policy indicated intervention was an to a chair or bed. The policy indicated the number of the placed in excessive dose the the placed or indications for its use; or indications for its use; or indiverse consequences which should be reduced or indications of the elementary of the placed in the plac	F0329	F329DRUG REGIMEN IS FR FROM UNNECESSARY DRI . REVIEWED PRN FLO	DATE 08/29/2011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV	/EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETEI)
		155232	B. WIN			08/12/2011	
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
					11, 11, 11, 10000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CO	MPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG		964	DATE
	· .	n were monitored for			SHEETS FOR RESIDENT # #63 &	.01,	
		on of the medication			#71 FOR CURRENT		
	for 3 of 5 residents reviewed with				APPROPRIATE		
	orders for as needed pain medication				DOCUMENTATION.		
	in a Stage 2 Sa	imple of 30. (Resident					
	#'s 61, 63, and	71)			2. ALL RESIDENTS HA	/E	
					THE POTENTIAL TO BE		
	Findings includ	e:			AFFECTED. ALL		
	9				RESIDENTS MAR'S WERE CHANGED TO INDICATE "S	I .	
	1) The clinical	record for Resident			PRN FLOW SHEET".		
	#61 was reviewed on 8/10/11 at 2:10						
					3. ALL NURSES HAVE		
	p.m.				BEEN EDUCATED REGARD	DING	
	Diamaga far I	Desident #64 included			THE USE OF		
	_	Resident #61 included,			THE PRN FLOW SHEET.		
	but were not lin	•			(ATTACHMENT A) 4. THE DON/DESIGNER	_	
	disorder, chron	•			WILL REVIEW RESIDENTS	-	
	depression, and	d chronic abdominal			WITH PRN		
	pain.				MEDICATIONS ON		
					SCHEDULED WORK DAYS	AS	
	Resident #61 h				FOLLOWS: DAILY		
	Hydrocodone -	APAP (a narcotic pain			TIMES 1 WEEK, 3 TIM	ES	
	medication) 7.5	5-500 mg (milligrams),			WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY		
	dated 3/8/11, o	ne tablet three times a			FOR 2 MONTHS AND		
	day prn (as nee	eded) for pain.			RANDOM FOR 3 MONTHS		
	,	•			(ATTACHMENT I)		
	The "narcotic s	ign out sheets" for			, ·		
		sted the dates and			RESULTS OF THESE REVI	- I	
					WILL BE DISCUSSED DURI	NG	
	times the "as needed" Hydrocodone - APAP pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:				THE		
					FACILITY QUARTERLY QA MEETINGS.		
					WILLTHAOU.		
					CORRECTION DATE: AUGU	JST	
					29, 2011		
	0/40/44 + 44 5	•					
	6/13/11 at 11:30						
	7/11/11 at 1:00	p.m.					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232 A. BUILDING B. WING			li i	E SURVEY PLETED /2011		
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP CO ST NORTH H ST ITY, IN46933	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(MAR) and the Sheet for June Resident #61, I related to the I medication have dates and time nursing notes froted above la related to the pheen given as a narcotic record. 2.) The clinica #63 was review a.m. Diagnoses for but were not lir retention, benigh hypertrophy (B disease, and clinical was a series of the control of the contr	Administration Record PRN Medication Flow and July 2011 for acked any information dydrocodone - APAP ring been given on the sented above. The or the dates and times cked any information ain medication having signed out on the second for Resident wed on 8/11/11 at 9:50 Resident #63 included, mited to, urinary gn prostatic PH), chronic kidney				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MULTIP A. BUILDING		NSTRUCTION 00	(X3) DATE: COMPL 08/12/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		I			06/12/2	011
TWIN CI	TY HEALTH CARE		I		TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	ΊΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	HCL (hydrochlowas signed out	oride) pain medication for the resident. ere not limited to, were					
	6/19/11 at 11:30 6/24/11 at 10:00 6/26/11 at 8:00 7/21/11 at 7:00	0 a.m. a.m.					
	(MAR) and the Sheet for June Resident #63, I related to the C medication hav dates and times nursing notes for noted above lacrelated to the p	ing been given on the solution noted above. The for the dates and times cked any information ain medication having signed out on the					
	Director of Nurs at 8:50 a.m., ac was requested documentation the narcotic pai	nterview with the sing (DoN) on 8/12/11 dditional information related to the lack of of administration of a medication on the s noted above for nd #63.					
	_	view on 8/12/11 at DoN indicated she					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/12/2	LETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST	1 00/12/2	
(X4) ID	TY HEALTH CARE	TATEMENT OF DEFICIENCIES	1	ID ID	TY, IN46933		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	provide related documentation the narcotic pair out on the date. Resident #61 a 4.) The clinical #71 was review a.m. Diagnosis for R but were not limbipolar disorder obstructive pulnot the clinical receptor was a complaints of grain in her kneed A recapitulation dated 7/6/11, in had an order for Acetaminopher medication) 5/5 times a day for also had a currently drocodone (v7.5/325 mg tab needed for pair	of administration of in medication signed is and times for and #63 noted above. record for resident ared on 8/10/11 at 10:15 desident #71 included, and the included are inc					
1		sted the dates and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155232	B. WIN			08/12/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		eeded" Hydrocodone					
	· •	n was signed out for ncluded, but were not					
		·					
	limited to, were the following dates and times:						
	and times.						
	7/16/11 at 8:00 p.m.						
	7/19/11 at 0.00 p.m.						
	7/20/11 at 9:30	•					
	7/22/11 at 10:0	•					
		p.m. and 10:00 p.m.					
		para and recor para					
	The Medication	Administration					
	Records (MAR) for Resident #71,					
	,	rmation related to the					
	_	rocodone medication					
	•	ven on the dates and					
	•	ove. The nursing					
		ates and times noted					
	above lacked a	ny information related					
	to the pain med	lication having been					
	•	d out on the narcotic					
	record.						
	During an inter	view with the					
	Consultant RN	on 8/12/11 at 11:30					
	a.m., additional	information was					
	requested relat	ed to the lack of pain					
	monitoring for t	he narcotic medication					
	signed out for F	Resident #71 on the					
	dates and time	noted above.					
	The facility faile	ed to provide any					
	•	mation as of exit on					
	8/12/11.						

OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	00	(X3) DATE COME	ESURVEY
	155232	B. WING		08/12/	2011
PROVIDER OR SUPPLIER		627 E	FADDRESS, CITY, STATE, ZIP COE AST NORTH H ST CITY, IN46933	E	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	627 E	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROVIDER'S FOR RESID FROM UNNECESSAR 1. REVIEWED PR SHEETS FOR RESID #63 & #71 FOR CURRENT APPROPRIATE DOCUMENTATION. 2. ALL RESIDENT THE POTENTIAL TO E AFFECTED. ALL RESIDENTS MAR'S VICHANGED TO INDICAPRN FLOW SHEET". 3. ALL NURSES FROM SHEET SHEET SHOW SHEET SHOW SHEET SHOW SHEET SHOW SHEET SHOW SHEET SHEED SHEET SHOW SHEET SHEED SHEED SHEET SHEED SHEET SHEED SHEET SHEED SHEET SHEED SHEET SHE	S HAVE BE VERE TE "SEE VERE TE "SEE IAVE GARDING ET.	(X5) COMPLETION DATE 08/29/2011	
3.1-48(a)(3)			4. THE DON/DESI WILL REVIEW RESIDI WITH PRN MEDICATIONS SCHEDULED WORK I FOLLOWS: DAILY TIMES 1 WEEK, WEEKLY FOR 3 WEEI TIMES WEEKLY FOR 2 MONTHS RANDOM FOR 3 MON (ATTACHMENT I) RESULTS OF THESE WILL BE DISCUSSED THE FACILITY QUARTERL MEETINGS. CORRECTION DATE:	ENTS ON DAYS AS 3 TIMES (S, 2 AND ITHS REVIEWS DURING LY QA	

	'		LDING G	00	COMPL	ETED
	t		627 EA	ST NORTH H ST		
(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3	(X5) COMPLETION DATE
free of any signific Based on record the facility faile from significant 1 of 4 residents administration medication as physician relate pressure reading Sample of 30. Findings include 1.) The clinica #71 was review a.m. Diagnosis for Fibut were not limbipolar disorder obstructive pulled the diagnosis of hyrisk for complicating the diagnosis. for this problem not limited to, "as ordered" an	rant medication errors. rd review and interview, d to ensure it was free t medication errors for s reviewed for of blood pressure ordered by the ed to elevated blood ngs in a Stage 2 (Resident #71) de: I record for resident wed on 8/10/11 at 10:15 Resident #71 included, mited to, hypertension, r, and chronic monary disease. Idan problem, dated ed the resident had a repertension and was at eations associated with Two of the approaches in included, but were Administer medications d "Monitor blood	FO	333	1.RESIDENT #71 ASSESS AND NO HARM NOTED. 2. ALL RESIDENTS HAVE POTENTIAL TO BE AFFECT RESIDENTS WITH PRN CLONIDINE ORDERS HAVE BEEN REVIEW TO ENSURE PROMINISTRATION OF MEDICATIONS. (ATTACHMENT A) 4. THE DON/DESIGNEE VEREVIEW RESIDENTS WITH BLOOD PRESSUR ORDERS TO ENSURE PROMINISTRATION OF PROMEDICATION OF PROMEDICATION OF PROMEDICATION OF PROMEDICATION OF PROMEDICATION OF PROMEDICATION OF PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMINISTRATION OF PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMINISTRATION OF PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAILY TIMES 1 WEEK, 3 TO TENSURE PROMEDICATIONS ON SCHEDULED WORK DAYS AS FOLLOW DAYS DAYS AS FOLLOW DAYS DAYS DAYS DAYS DAYS DAYS DAYS	THE CTED. /E OPER DS. VILL E COPER N /S: FIMES	08/29/2011
A recapitulation of physician's orders,				WEEKLY FOR 3 WEEKS, TIMES WEEKLY FOR 2	2	
	TY HEALTH CARE SUMMARY S (EACH DEFICIENT REGULATORY OR PRODUCT OR	PROVIDER OR SUPPLIER TY HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure it was free from significant medication errors for 1 of 4 residents reviewed for administration of blood pressure medication as ordered by the physician related to elevated blood pressure readings in a Stage 2 Sample of 30. (Resident #71) Findings include: 1.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered."	PROVIDER OR SUPPLIER TY HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure it was free from significant medication errors for 1 of 4 residents reviewed for administration of blood pressure medication as ordered by the physician related to elevated blood pressure readings in a Stage 2 Sample of 30. (Resident #71) Findings include: 1.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered."	PROVIDER OR SUPPLIER TY HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure it was free from significant medication errors for 1 of 4 residents reviewed for administration of blood pressure medication as ordered by the physician related to elevated blood pressure readings in a Stage 2 Sample of 30. (Resident #71) Findings include: 1.) The clinical record for resident #71 was reviewed on 8/10/11 at 10:15 a.m. Diagnosis for Resident #71 included, but were not limited to, hypertension, bipolar disorder, and chronic obstructive pulmonary disease. A health care plan problem, dated 6/1/11, indicated the resident had a diagnosis of hypertension and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, "Administer medications as ordered" and "Monitor blood pressure as ordered."	DENTIFICATION NUMBER: 155232 A BUILDING B WING	OF CORRECTION IDENTIFICATION NUMBER: 155232 1

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND FLAN	OF CORRECTION	155232		LDING	00	08/12/2	
		100202	B. WIN		PRESIDENT CONTROL OF CORP.	00/12/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	dated 7/6/11, in	dicated Resident #71			MONTHS AND		
	was to have he	r blood pressure taken			RANDOM FOR 3 MONTHS	3	
	3 times daily. 1	The orders indicated		(ATTACHMENT I)			
	the resident wa	s to receive Clonidine			RESULTS OF THESE REVI	EWS	
	0.1 mg [milligra	m] one tablet as			WILL BE DISCUSSED		
	needed if the re	esident's systolic b/p			DURING THE FACILITY	_	
	,	e] was above 150 and			QUARTERLY QA MEETING	iS.	
	her diastolic b/p	was above 90.			CORRECTION DATE: AUG	UST	
					29, 2011		
	•	of the June and July					
		ninistration records					
	` ′	ollowing dates and					
		ents b/p was elevated					
		e for the as needed					
	Clonidine to ha	ve been given:					
	6/29/11 at 10 p.	.m 167/98					
	7/15 at 10 p.m.						
	7/17/11 at 10 p.	.m154/90					
	The MAR and r	nursing notes for these					
	dates and times	s lacked any					
	information rela	ited to the blood					
	•	ation having been					
	-	ed by the physician					
	1	w-up blood pressure					
	reading having	been taken.					
	During an inter	view with the					
		nd Director of Nursing					
	(DoN) on 8/11/	11 at 8:20 a.m.,					
		mation was requested					
	related to the la	ack of medication					
	having been giv	ven on the dates noted					
	above as order	ed by the physician for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUILDING	00 COMPLETED 08/12/2011		
		133232	B. WING	DDDEGG GETY GTATE ZID GODE	00/12/2011	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE		I	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG		pressure readings.	IAG	,	DAIL	
	During an inten 11:30 a.m., the had no informa to the medicatio	view on 8/12/2011 at DoN indicated she tion to provide related on having not been ates and times noted				
F0428 SS=E	reviewed at least of pharmacist. The pharmacist meto the attending pharmacist, and these upon. Based on record the facility failed pharmacist note irregularities in administration of residents (Resilements) reviewed for as needed metodomatical to identify the pharmacist of the facility failed for as needed metodomatical for a supplementation of the facility failed for as needed metodomatical for a supplementation of the facility failed for as needed metodomatical for a supplementation of the failed to identify the failed for a supplementation of the failed for a supplementation of the failed failed for a supplementation of the failed for a supplementation of the failed failed for a supplementation of the failed failed for a supplementation of the failed	ed and reported	F0428	F428 DRUG REGIMEN REVINEEPORT IRREGULAR, ACT 1-3A. REVIEWED PRN FLO SHEETS FOR RESIDENT # #63 & #71 FOR CURRENT APPROPRIATE DOCUMENTATION. 1-3B. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENTS MAR'S WEATHER COMMENTATION OF THE POTENTIAL TO SE AFFECTED. ALL RESIDENTS MAR'S WEATHER COMMENTATION OF THE POTENTIAL TO SE AFFECTED. ALL RESIDENTS MAR'S WEATHER COMMENTATION OF THE POWENTATION OF THE PO	CON W 61, EERE SEE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	00	COMPL	ETED
		155232				08/12/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
					ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	from the hospit	al in a Stage 2 sample			USE		
	of 30.				OF THE PRN FLOW SHEET	ī.	
	01 00.				(ATTACHMENT A) THE		
					CONSULTING		
	Findings includ	e:			PHARMACIST HAS BEEN		
					EDUCATED TO MEET WITH	1	
	1.) The clinical	record for Resident			THE D.O.N.		
	#61 was review	ed on 8/10/11 at 2:10			DURING EACH VISIT.		
	p.m.				4 OD THE DON/DEGIONE	_	
	r				1-3D. THE DON/DESIGNEE WILL REVIEW RESIDENTS		
	Diagnoses for I	Resident #61 included,			WITH PRN MEDICATIONS		
	_				SCHEDULED WORK DAYS	-	
	but were not lin	' !			FOLLOWS:	70	
	disorder, chron	•			DAILY TIMES 1 WEEK, 3 TII	MES	
	depression, and	d chronic abdominal			WEEKLY FOR 3 WEEKS, 2		
	pain.				TIMES		
					WEEKLY FOR 2 MONTHS A	√ND	
	Resident #61 h	ad an order for			RANDOM FOR 3 MONTHS		
	Hydrocodone -	APAP (a narcotic pain			(ATTACHMENT I)		
	_	5-500 mg (milligrams),			DURING CONSULTING		
	•	ne tablet three times a			PHARMACIST VISIT SHE W	/ILL	
					MEET WITH D.O.N./		
	day prn (as nee	eded) for pain.			DESIGNEE TO REVIEW		
					RECOMMENDATIONS.		
	The "narcotic s	ign out sheets" for			44 MEDICATION EDDOD		
	Resident #61 li	sted the dates and			4A. MEDICATION ERROR REPORT COMPLETED FOR	,	
	times the "as n	eeded" Hydrocodone -			RESIDENT #9	`	
		dication was signed out			WITH PHYSICIAN		
	•	. Included, but were			NOTIFICATION.		
					11011110/1110111		
		vere the following			4B.ALL RE-ADMITS HAVE 1	THE	
	dates and times	S:			POTENTIALTO BE AFFECT	ED.	
					ALL RE-ADMISSION ORDE	RS	
	6/13/11 at 11:30	0 a.m.			WILL BE REVIEWED BY		
	7/11/11 at 1:00	p.m.			DON/DESIGNEE		
	7/19/11 at 4:30	-			TO ENSURE PROPER		
	1.10,17 40 1.00	k			TRANSCRIPTION OF ORDE	∃RS.	
	The Medication	Administration Record			40 THE MILESES = ==		
					4C. THE NURSES HAVE BE		
	(wak) and the	PRN Medication Flow	1		RE-EDUCATED ON PROPE	.K	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN	IG		08/12/2	011
NAME OF I	PROVIDER OR SUPPLIEI	·	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDER OR SOLI ELE			627 EAS	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Sheet for June	and July 2011 for			TRANSCRIPTION OF ORDE	ERS.	
	Resident #61,	lacked any information			(ATTACHMENTA) THE		
	related to the H	Hydrocodone - APAP			PHARMCIST WAS EDUCATED THAT SHI	=	
	medication hav	ing been given on the			MUST MEET WITH	_	
	dates and time	s noted above. The			D.O.N./DESIGNEE		
	nursina notes t	or the dates and times			DURING EACH MONTHLY \	/ISIT	
	_	cked any information			TO FACILITY.		
		pain medication having			4D ALL DE ABAUCCIC:		
		signed out on the			4D. ALL RE-ADMISSION ORDERS WILL BE REVIEW	ED	
	narcotic record	•			BY	בט	
		cord indicated the			DON/DESIGNEE TO ENSUR	RE	
		acy consultant had			PROPER TRANSCRIPTION	OF	
		dent #61's clinical			ORDERS SCHEDULED WO	RK	
					DAYS AS FOLLOWS: DAILY	•	
		/11 and 7/26/11. The			TIMES 1 WEEK, 3 TIMES		
	ı ·	sultant gave no			WEEKLY FOR 3 WEEKS, 2 TIMES		
	information/ma				WEEKLY FOR 2 MONTHS A	ND	
		ons related to the			RANDOM FOR 3 MONTHS		
	•	between the MAR,			(ATTACHMENT B) THE		
	PRN Medication	on Flow Sheet, and the			PHARMCIST WILL REVIEW		
	narcotic sign o	ut sheets.			RE-ADMISSION ORDERS T		
					ASSURE NO TRANSCRIPT	ION	
					ORDERS DURING VISIT.		
	2.) The clinica	I record for Resident					
	#63 was review	ved on 8/11/11 at 9:50					
	a.m.				RESULTS OF THESE REVI	EWS	
					WILL BE DISCUSSED		
	Diagnoses for	Resident #63 included,			DURING THE FACILITY	0	
	_	nited to, urinary			QUARTERLY QA MEETING: CORRECTION DATE: AUGU		
	retention, beni	•			29, 2011	101	
	l '	PH), chronic kidney			= v, =v · ·		
	disease, and c						
	i discase, and C	птопіс рапт.					
	Resident #63 had an order for						
	Oxycodone Hy	drochloride (a narcotic					
	•	n) 5 mg (milligrams),					

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIEF		627 EA	ADDRESS, CITY, STATE, ZIP ST NORTH H ST ITY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	· ·	1/2 a tablet every four needed) for pain.				
	Resident #63 li times the "as n HCL (hydrochlowas signed out Included, but we the following data of 19/11 at 11:3 6/24/11 at 10:0 6/26/11 at 8:00 7/21/11 at 7:00 The Medication (MAR) and the Sheet for June Resident #63, related to the Comedication have dates and time nursing notes for noted above la related to the president with the process of the p	0 a.m. 0 a.m. a.m. Administration Record PRN Medication Flow and July 2011 for lacked any information Expression on the s noted above. The for the dates and times cked any information wain medication having signed out on the				
	facility's pharm reviewed Resid	_				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		NSTRUCTION 00	(X3) DATE S COMPL		
1111012111	or condition	155232	A. BUI B. WIN	LDING IG		08/12/2	
NAME OF I	PROVIDER OR SUPPLIER		D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	11, 1140955		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· E	DATE
		ons related to the					
		netween the MAR, n Flow Sheet, and the					
	narcotic sign or	·					
	l '	record for resident #71					
		on 8/10/11 at 10:15					
	a.m.						
	Diagnosis for R	Resident #71 included,					
	but were not lin	nited to, hypertension,					
	bipolar disorde						
	obstructive puir	nonary disease.					
	The clinical rec	ord indicated resident					
	#71 had proble	ms with pain					
		nd had frequent					
	complaints of g	eneralized pain and					
		cs and icgs.					
	A recapitulation	of physician's orders,					
	· ·	idicated the resident					
		r Hydrocodone (with n) (a narcotic pain					
		600 mg one tablet three					
	l '	pain. The resident					
	also had a curr						
	,	with acetaminophen)					
	needed for pair	1 every 4 hours as					
		ign out sheets" for					
		sted the dates and					
		eeded" Hydrocodone n was signed out for					
	•	ncluded, but were not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	A. BU	MULTIPLE COI IILDING	NSTRUCTION 00		X3) DATE S COMPL 08/12/2	ETED
			B. WI		DDRESS, CITY, STA	ATE, ZIP CODE	· -· -	
NAME OF I	PROVIDER OR SUPPLIE	R		1	ST NORTH H S			
TWIN CI	TY HEALTH CARE			1	TY, IN46933			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCI	VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	≣	COMPLETION DATE
IAG	 	e the following dates		IAG	DEI	ICIENCT)		DATE
	and times:	e the following dates						
	and times.							
	7/16/11 at 8:00) p.m.						
	7/19/11 at 11:0	•						
	7/20/11 at 9:30) p.m.						
	7/22/11 at 10:0	00 p.m.						
	7/25/11 at 6:00) p.m. and 10:00 p.m.						
		n Administration						
	,	R) for Resident #71,						
		ormation related to the						
	1	drocodone medication						
		iven on the dates and pove. The nursing						
		ates and times noted						
		any information related						
		dication having been						
		d out on the narcotic						
	record.							
	During an inter	rview with the						
	Consultant RN	I on 8/12/11 at 10:00						
	a.m., additiona	al information was						
	1 .	ted to the lack of pain						
		the narcotic medication						
		Resident #71 on the						
	dates and time	e noted above.						
	The facility fail	ed to provide any						
		ed to provide any rmation as of exit on						
	8/12/11.	mation as of Exit Off						
	J. 12/11.							
	The clinical red	cord indicated the						
		rmacist reviewed the						
FORM CMS-2	2567(02-99) Previous Versi		I4K711	Facility I	D: 000137	If continuation she	eet Pa	ge 78 of 92

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIEF		627 EA	ADDRESS, CITY, STATE, ZIP O ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAG	resident's clinic During an inter of Nursing on 8 she indicated to pharmacy recordented to the value of the v	view with the Director 8/12/11 at 10:15 a.m., here were no mmendations made isit on 7/26/11. record for Resident # 9 at 8/11/11 at 9:30 a.m. Resident #9 included, mited to, chronic leg as stasis, congestive coholic liver disease, al retardation and as readmitted from the 4/11 following ellulitis, alcoholic liver iabetes mellitus. rders sent with the ed, but were not limited g three orders as noted	IAG			DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155232	B. WIN	_		08/12/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TIA/INI OI	TVIIEALTILOADE				ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	ote of any stop date.					
		nedication was to be					
	-	umented in error for					
	1	a.m. and 7 p.m The					
	•	twice daily for three					
	l •	nd then rewritten for					
	,	a stop date now					
		3/11 (a 21 day time					
	period).						
		5 % (a spray used for					
	,	sprays inhaled daily.					
		n was transcribed to					
		uticasone 0.5 % nasal					
		each nostril daily" The					
	time the medica	ation was to be given					
		n error for 7 a.m. and 8					
	p.m., not once	daily. This medication					
	was given twice	e daily through 8/11/11.					
	Saline nasal sp	ray (a moisture nasal					
	spray) 1 spray	each nostril several					
	times daily. Th	is medication was					
	transcribed to t	he MAR as "Saline					
	nasal spray 1 s	pray each nostril three					
	times daily." Th	ne saline nasal spray					
	was documente	ed as having been					
		aily through 8/11/11.					
		-					
	The clinical rec	ord lacked					
	documentation	of the Levaquin,					
	Fluticasone, an	d/or Saline nasal					
		een clarified with the					
	' ' '	e time of readmission					
	and/or any othe						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155232		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	l ′	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	on 8/11/11 at 1 information was the Levaquin hanother 21 day Levaquin, Fluting and Saline has as noted above. During an inter of Nursing on 8 she indicated the wout whether the the Levaquin to given for anoth. The clinical reconsultant pharesident's clinical pharmacy reconsultant of Nursing on 8 she indicated the pharmacy recordated to the volume of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas provided by 8/12/11 at 8:00 indicated the minimal stress of the current pharmacist Mowas pharm	and Director of Nursing 150 p.m., additional 150 p.m., additional 151 requested related to 151 aving been given for 151 s. and the errors in the 152 casone nasal spray, all spray administration 152. Aview with the Director 151 aview with the Director 151 aview with the Director 152 cas still trying to find 153 aview and 154 aview with the Director 151 aview with					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CC A. BUILDING B. WING	00	I	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP C ST NORTH H ST TY, IN46933	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	the consultation results of all me administration (

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COI	TE SURVEY MPLETED 2/2011
	PROVIDER OR SUPPLIER		STRE 627	ET ADDRESS, CITY, STATE EAST NORTH H ST 5 CITY, IN46933	E, ZIP CODE	
TWIN CITAL (X4) IID PREFIX TAG F0441 SS=D	SUMMARY S (EACH DEFICIEN REGULATORY OR The facility must e Infection Control F a safe, sanitary an and to help prever transmission of dis (a) Infection Contr The facility must e Program under wh (1) Investigates, or infections in the fa (2) Decides what p isolation, should b resident; and (3) Maintains a rec corrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread	stablish an Infection Control nich it - controls, and prevents cility; crocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETION DATE
	communicable dis lesions from direct their food, if direct disease. (3) The facility mulhands after each owhich hand washin professional practic. (c) Linens Personnel must has transport linens so infection. Based on obserecord review, the ensure nurses to their their transport lines.	est prohibit employees with a ease or infected skin contact with residents or contact will transmit the est require staff to wash their direct resident contact for angles indicated by accepted ce. andle, store, process and as to prevent the spread of east operation, interview, and the facility failed to did not recontaminate er hand washing for 1	F0441	PREVENT SPI 1A.NURSE IM	N PROPER HAND	08/29/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155232	B. WIN			08/12/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ST NORTH H ST		
TWIN CI	TY HEALTH CARE				TY, IN46933		
				l			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1	ss observations and			1B. NURSING STAFF EDUCATED ON HAND		
	failed to ensure soiled linens were not				WASHING TECHNIQUE WI	ГН	
	1 '	floor after removing			REGARDS TO INFECTION		
	them from bed	s for 1 of 2			CONTROL.(ATTACHMENT	K)	
	observations.	[LPN #1, Housekeeper			1C. NURSING STAFF		
	#2]				PERFORMED HAND WASH	ING	
					TECHNIQUE.		
	Findings includ	le:			(ATTACHMENT K) 1D. DON/DESIGNEE TO		
					COMPLETE AUDITS ON		
	1. LPN #1 was	s observed passing			SCHEDULED		
		11:01 a.m. on 8/9/11 to			DAYS OF WORK ON ALL		
		The LPN entered the			SHIFTS DAILY TIMES ONE		
		n and washed her			WEEK, 3X WEEKLY FOR 3		
		ied her hands with			WEEKS,		
					2X WEEKLY FOR 2 MONTH AND RANDOM FOR 3 MON		
	1	nd threw the paper			(ATTACHMENT L)	ins.	
	1	She used her clean			(ATTACHMENT 2)		
		turn off the faucet. She					
	_	and checked Resident					
	_	ar. She removed the			2A. SOILED LINEN REMOV	ED	
	-	shed her hands. She			FROM FLOOR AND		
	turned the fauc	cet off with her clean			HOUSEKEEPING STAFF IMMMEDIATELY		
	bare hands.				EDUCATED.		
					2B. HOUSEKEEPING AND		
	LPN #1 was ob	oserved at 11:19 a.m.			NURSING STAFF EDUCATE	ED	
	on 8/9/11, was	hing her hands. She			ON PROPER		
		cet off with her clean			LINEN TECHNIQUE.		
	bare right hand				(ATTACHMENT M)		
	l and right harre				2C. HOUSEKEEPING AND		
	During an inter	view with the Director			NURSING STAFF EDUCATE	-D	
	_	3/11/11 at 3:45 p.m.,			ON		
		he nurse should have			PROPER LINEN TECHNIQU	JE.	
					(ATTACHMENT C)		
		vels to turn of the			2D. DON/DESIGNEE TO		
	faucet.				COMPLETE AUDITS ON	NDI/	
					SCHEDULED DAYS OF WO	JKK	
	The current un	dated "Handwashing			DAILY TIMES 1 WEEK, 3X		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 08/12/2	LETED
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP CODE AST NORTH H ST ITY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	at 12:35 p.m., t The Procedure	s provided on 8/12/11 by the Administrator. indicated the faucets ed of with a paper towel after hands are		WEEKLY FOR 3 WEEK WEEKLY FOR 2 MONT RANDOM FOR 3 MON (ATTACHMENT H) RESULTS OF THESE F WILL BE DISCUSSED DURING THE FACILIT QUARTERLY QA MEET	HS AND THS. REVIEWS Y TINGS.	
	1:00 p.m. hous in room # 126 c room. The con from the 2 resid room were in a	ervation on 8/8/11 at ekeeping staff #2 was cleaning the resident's applete set of bed linens dent's beds in the pile on the floor. The in any type of bag.		29, 2011		
	the observation would put the list she was finished. The housekeep	staff #2 at the time of a, she indicated she nens in a bag when ad with the cleaning. Sing staff continued to and did not place the				
	1:30 p.m. hous picked the liner	ervation on 8/8/11 at ekeeping staff #2 as up off the floor and a bag and removed the room.				
	of Nursing on 8	view with the Director 3/11/11 at 3:30 p.m. she s should not be placed				

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	e survey pleted /2011
	PROVIDER OR SUPPLIER	2	627 EA	ADDRESS, CITY, STATE, ZIP (ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		he indicated linens ed in bags when the bed.				
	policy, dated 9 Making (unoco provided by th	current facility 0/05, titled "Bed cupied) Procedure", ne director of nursing 2:35 p.m. indicated,				
	resident who i	prepare a bed for a s not occupying it at r admission of a				
	head to foot o	ed linen and roll from f bed and place in gat foot of bed or in a				
	3.1-18(I) 3.1-19(a)(1)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	08/12/2011	
		155232	B. WIN			08/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			I	ST NORTH H ST TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		naintain clinical records on	+	IAU			DATE
F0514 SS=D	each resident in ac professional stand complete; accurate	accordance with accepted ards and practices that are ely documented; readily stematically organized.					
	information to iden the resident's asse and services provi- preadmission scre State; and progres		F0	514			00/20/2011
		d review and interview	F0	514	E514 DEQ		08/29/2011
	•	d to ensure blood			F514 RES RECORDS-COMPLETE		
	•	nd sliding scale insulin			/ACCURATE/ACCESSIBLE		
		ed in the clinical record ents reviewed with			1. FOR RESIDENT #73	_	
		ens for blood sugar			GLUCOSE RESULTS WERE OBTAINED	Ξ	
		sliding scale insulin to			FROM 24 HOUR SHEETS A	.ND	
	_	d in a Stage 2 sample			PLACED ON CHART RECO		
	of 30. (Resider						
	·	,			2. ALL RESIDENTS WIT GLUCOSE MONITORING	ΤΗ	
	Findings include				ORDERS WERE REVIEWED.		
	•	record for Resident			3. NURSES WERE		
	#73 was review	ed on 8/8/11 at 1:30			EDUCATED NEW GLUCOS	E	
	p.m.				MONITORING PROCEDURES.(ATTACHME	-NT	
	Pacident #73's	current diagnoses			A)	-111	
		ere not limited to,					
	-	is, morbid obesity and			4. THE DON/DESIGNER		
	osteoarthritis.	io, morbid obodity and			WILL REVIEW RESIDENTS WITH		
	ostobartimus.				BLOOD GLUCOSE ORDER	ls	
	Resident #73 h	ad physician's orders			TO ENSURE PROPER		
	for the following				ADMINISTRATION OF SLID	ING	
		-			SCALE ORDERS ON SCHEDULED WORK DAYS		
	A. Metformin (a	n oral diabetic			DAILY TIMES 1 WEEK, 3X		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR OO COMPLETE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	08/12/2	
		155232	B. WIN			08/12/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
T\\/\ \ \C\	TY HEALTH CARE				ST NORTH H ST		
				L	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG			+	IAU	WEEKLY		DATE
	l '	00 milligrams 1 orally			FOR 3 WEEKS, 2X WEEKL	Y	
	daily. The ongi	inal date of this order			FOR 2 MONTHS AND RANI		
	was //10/11.				FOR 3 MONTHS.		
	P Monitor bloo	d glucose levels			(ATTACHMENT I)		
		nd at bedtime. 6:30			RESULTS OF THESE REVI	EWS	
		n., 4:30 p.m. and 9:00			WILL BE DISCUSSED DUR		
	·	nal date of this order			THE FACILITY QUARTERL	Y QA	
	·	uly 21, 2011 an order			MEETINGS.		
		decrease blood			CORRECTION DATE: AUGI	JST	
		ring to twice daily 6:30			29, 2011		
	a.m. and 4:30 p	-					
	a.m. and 4.00	7.III.					
	C. Administer N	Novolog sliding scale					
		e based on blood					
	_	according to the scale					
	below,						
	,						
	151 - 200 = 6 u	ınits					
	201 - 250 = 10	units					
	251 - 300 = 15	units					
	greater than 30	0 call the physician.					
	_						
	A health care p	lan, dated 6/4/11					
	indicated Resid	dent #73 had a					
	problem listed a	as, the resident has a					
	diagnosis of dia	abetes mellitus and is					
	_	riencing hypo or					
	hyperglycemia.	Interventions for this					
	problem include	ed, monitor blood					
	sugars as orde	red and administer					
	medication as	ordered.					
		lune and July 2011					
	"Blood Glucose	e Monitoring" records					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	LETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	NDDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	for Resident #7 documentation	73 lacked of any blood glucose ollowing dates and		TAG	DEFICIENCY)		DATE
	A. June 20, 6:3 4:30 p.m. and 9 B. June 30, 9:0	•					
	July						
	A. July 7, 4:30	p.m.					
	B. July 9, 4:30	p.m.					
	C. July 11, 9:00) p.m.					
	D. July 23, 4:30) p.m.					
	E. July 24, 4:30) p.m.					
	F. July 26, 6:30	a.m. and 4:30 p.m.					
	G. July 27, 6:30	o a.m. and 4:30 p.m.					
	H. July 30, 6:30	a.m. and 4:30 p.m.					
	of Nursing on 8 additional information in the latest to th	view with the Director 3/11/11 at 8:30 a.m. mation was requested ack of blood sugar dates and times noted					

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED '2011
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			627 EA	ADDRESS, CITY, STATE, ZIP C ST NORTH H ST TY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	of Nursing on 8 indicated all of noted above w on the nursing She further ind report sheets w clinical record. nursing staff she results on the state of the results on the state of the results on the results of the r	view with the Director 8/11/11 at 3:10 p.m. she the blood sugar results ere found documented 24 hour report sheets. icated the 24 hour vere not a part of the She indicated the nould have documented he "Blood Glucose cord" which is a part of ecord.				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 08/12/2	ETED
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST FY, IN46933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0520 SS=D	and assurance condirector of nursing designated by the members of the far. The quality assess committee meets a issues with respect assessment and an ecessary; and deappropriate plans identified quality descept insofar as a the compliance of requirements of the Good faith attemption in the compliance of requirements of the used as a basis. Based on intervolution and correct be used as a basis. Based on intervolution and correct in the compliance of requirements of the compliance of requirements of the used as a basis. Based on intervolution and correct in the compliance of requirement applied and respectively. The committee failed in the compliance of the committee failed in the committee failed in the committee of the committee failed in the committee of t	sment and assurance at least quarterly to identify but to which quality assurance activities are evelops and implements of action to correct efficiencies. Cretary may not require ecords of such committee such disclosure is related to such committee with the is section. Its by the committee to but quality deficiencies will not as for sanctions. View, the facility's ment and Assurance end to develop and ropriate plans of action cient practices of the Annual and State Licensure	F0	520	F520 QAA COMMITTEE-MEMBERS/ME QUARTERLY/PLANS 1.CONCERNS WERE IMMEDIATELY ADDRESSED 2.CONCERNS WERE ADDE TO QA LOG FOR MONITOR 3.AN ACTION PLAN WAS DEVELOPED FOR EACH AF OF CONCERN. 4.AUDITS F ACTION PLANS WILL BE REVIEWED DURING QA MEETINGS. (ATTACHMENT I) QUARTERLY CHANGES WERE BE MADE AS NECESSARY ASSURE APPROPRIATE PL OF ACTION TO CORRECT IDENTIFIED QUALITY	D. ID ING. REA ROM B & VILL TO	08/29/2011

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMP 08/12/2	LETED
NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE			p. with	STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
-	residents (Resident #'s 71, 63, and 61) reviewed for pain monitoring in a Stage 2 Sample of 30.			-	DEFECENCIES. CORRE DATE: AUGUST 29, 2011	CTION	
	the Administrate a.m., the DoN in had not identified orders for a result hospital were to the Resident #9 and concerns related medication administration adm	view with the DoN and or on 8/12/11, at 8:50 indicated the facility and the failure to ensure ident returning from a ranscribed correctly for d had not identified the ad to narcotic pain inistration for , 63, and 61 and no d been developed to					